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PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of receiving services from CWUA, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. **Upon check-in,** we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit card of Master Card, Visa, and Discover.

3. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract.

4. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If you insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.

5. Any unpaid charges over 90 days old will be turned over to an outside collection agency with an additional collection agency fee. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process.

   In the event a payment plan is needed the following will apply:
   Estimated amount due from patient $_____ due in monthly payments of $_____ beginning _____ and continuing until paid in full.

   Payments will be due promptly each month. In the event the monthly payment is not received as agreed the entire balance will become due at that time.

6. Returned checks are subject to a $30.00 return check fee.

   We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____ _____

Patient/Guardian Signature Date