FINANCIAL AGREEMENT

In order to avoid misunderstandings regarding fees and their payment, a complete discussion prior to scheduling of surgery is worthwhile. Please read and sign the following agreement. If you have any questions we will be happy to answer them.

I have been advised that the fee associated with my treatment, as of this date is $_____. I understand that the entire fee is due at the time of my surgery appointment or beginning of my treatment. If insurance is to be utilized as payment, the proposed procedure or treatment may be submitted to the insurance company in advance for predetermination of benefits and authorization. **I am responsible for the balance or difference between the total fee and the amount payable by my insurance company**, unless there is an explicit contract between my insurance company and doctors Zarrinkelk & Associates. I understand that the office of doctor Zarrinkelk is not obligated to apply for pre-authorization or determination of my insurance benefits. However, this service may be provided to me on the office's discretion.

I understand that I may be asked to pay my portion of the fee in full at the time of scheduling the surgical appointment.

I understand and agree that my insurance company may deny payment on all or part of the procedures performed by Doctors Zarrinkelk or Associates. If this occurs it will be my responsibility to appeal the insurance company's decision. In the case of denial of benefits or reduction of fees by the insurance company **the balance will become immediately due and I will be personally and wholly responsible** for the entire outstanding amount on my account. I understand that I am responsible for the entire outstanding amount on my account if insurance payment is not received by 90 days following my surgery.

I understand and agree that any balance remaining on my account or any credit granted shall be paid promptly in accordance with terms of the agreement. I also agree that the credit grantor may add one and one half percent (1.5%) per month to any balance owed. I also understand and agree to pay reasonable collection charges and / or attorney fees in case of default on payment.

I have received and read this office's Notice of Privacy Practices. I give permission to Dr. Zarrinkelk or Associates to use photographs or radiographs taken during my treatment in professional publications.

Name:_____

Signature:_____

Date:_____
Patient's name:_____