

Financial Agreement

1. Payment is required at the time of service.
2. All supplements/merchandise must be paid for on the day they are received/ordered.
3. For your convenience we accept cash, checks, Visa, MasterCard, and Discover Card.
4. Appointments must be cancelled at least 24 hours in advance. A fee of \$20 will be charged for an appointment cancelled less than 24 hours in advance. A fee of \$46 will be charged for a missed appointment that has not been cancelled.
5. A \$15 fee will be charged to patients whose checks are returned unpaid by their bank. As a courtesy, we will process your check once more before being referred to collections.
6. Accounts which are 60 days past due will be subject to interest charges, and accounts 90 days past due will be turned into collections.
7. Please be aware that Dr. Giles is not a contracted provider for any insurance company. However, as a courtesy to you, we will bill your insurance company for you. Any reimbursement will go directly to the patient.

I understand the above terms and conditions. I hereby assign benefits directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the doctor. In the event of a past due balance, I understand that interest will be charged at 18% per annum. I also understand that if collection action becomes necessary, I will be responsible for all collection fees, costs, and reasonable attorney's fees.

I authorize Dr. Giles to examine and treat any condition he deems appropriate. I give authority for all of these procedures to be performed. I understand that the Examination and X-Rays films will remain property of Bountiful Family Wellness Center. Copies may be requested for a nominal copying charge.

Patient/Responsible Party

Date

Please Initial

8. _____ I hereby authorize Dr. Giles and his office staff to phone me to remind me of my appointments.
9. _____ I authorize Dr. Giles to send me information through the mail, or through email.