PAYMENT POLICY

Examination fee is due at the time of service. **All products must be paid in full before ordering. All co-payments are due at the time of service.**

If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collection your claim. After 30 days, we will expect payment in full if you insurance company has not paid.

Returned NSF checks will be charges a service fee of $25.00.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO **JAMES K. CUTLER OD & ASSOCIATES, P.C.**, FOR ANY AND ALL SERVICES RENDERED TO ME BY DR. CUTLER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

The Estimated Insurance Payment remains the patient's responsibility and any unpaid portion must be paid by the patient upon demand. The patient agrees to be responsible for reasonable collection costs, sour and attorney fees should collection action become necessary. THIS AGREEMENT CONSTITUTES A PROMISE TO PAY. Finance charge of 1.50% per month is applied to balances 60 days past due. A fee up to 33.33% is added to accounts sent Out to Collections.

I also release any information regarding my treatment or condition in order to obtain payment for professional services.

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

Signature ______________________________

Relationship to Patient: ______________________

Date: ________________________________

HIPPA Acknowledgement (Copy of Acknowledgement in its entirety is in the lobby)

Signature ______________________________

Date: ________________________________