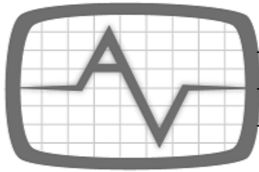

Private Pay Financial Agreement

Date:_______Name (please print):___________________________________Date of Birth:_________

This financial form is for patients paying out of pocket for our services. We ask that payments for services be paid at each visit. We accept cash, check, debit cards, or credit cards for your payment convenience.

If you have financial hardship, payment plans may be implemented. Please speak with the front office regarding this issue.

____
Initial

Pricing

Initial Evaluation fees can range from, $125 to $150, depending on the complexity of the patient.

Follow up visits range from, $100 to $125, depending on treatment plan and patient complexity.

____
Initial

YOU WILL BE CHARGED A $50 FEE IF:

- **You do not call and cancel within 24 hours of your appointment.**
- **You no show to an appointment.**
- **You are more than 15 minutes late and we have to cancel your appointment.**

____
Initial

I have read, understood and agree to the policies listed above. I have been given the opportunity to ask questions, and can be provided copies if requested.

Signed:______________________________Print Name:______________________________Date:___________

Address:____Phone:________________________