# FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Patient's Name_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment at the time of service, unless arrangements have been made in advance.

There will be a
$25 fee for returned checks and all delinquent accounts over 90 days will be turned over to a collection agency if deemed necessary.

Failure to show up for an appointment or late cancellation (without 24 hours notice), a no show or late cancellation fee of $50 will be charged to your account.

_____

Signature Of Person Responsible For Payment Date