PHYSICIAN'S CHOICE WELLNESS, LLC

Physician's Choice Wellness Financial Policy

I, _____ understand and agree that health and accident
PRINT NAME OF PATIENT
policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I discontinue utilizing the Physician's Choice Wellness program, any fees for professional services rendered me will be immediately due and payable. I understand that I have the option of making a payment arrangement with Physician's Choice Wellness if necessary but should my account become more than 60 days past due, with no payment being made, my account will be turned over to a collection agency and /or attorney to collect any unpaid balance at that time. I further understand that if my account is turned over to a collections agency and / or attorney due to non-payment, then I agree to be responsible for all reasonable fees necessary for the collection of the delinquent account including, but not limited to a collection agency fee of 50% of the balance due and costs and reasonable attorney fees of 33% of the balance due.

Insurance will be billed, if applicable, and the patient will be reimbursed or credited the full amount of the insurance payment.

_____ _____

Patient Signature Date