Dr. Michael Somai

104 S. Cory Dr., Edgewater, Fl. 32141

FINANCIAL POLICY

Your health is first and foremost. Medical care will always be rendered on the basis of need and no other factor will affect the quality of that care.

This is an agreement between Dr. Michael Somai as creditor, and the Patient/Debtor named on this form. By executing this agreement, you are agreeing to pay for all services received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show the current total patient balance that is the patient/debtor's responsibility.

PAYMENT OPTION IF YOU HAVE NO INSURANCE: You may choose to pay by _____Cash____Check____Credit Card or____ Care Credit on the day of treatment.

PAYMENT OPTION IF YOU HAVE INSURANCE: You choose to pay your deductible and any other out-of-pocket portion at the time services rendered by:____Cash____Check____or Credit Card

INSURANCE: We will bill your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay all the charges not covered by insurance or all the charges deemed your responsibility.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

There will be a 25.00 processing fee for all returned checks.

Patient Name:____________________________________

Responsible Party:_________________________________

Signature of Patient:________________________________

Date:__________________

Signature of Responsible Party:________________________

Date:___________________