3500 N. Causeway Blvd. Ste. 1410
Metairie, LA 70002
Phone: (504) 838-9919
Fax: (504) 834-3101

Financial Agreement Policy

I understand and agree that a health insurance policy is an arrangement between an insurance company and myself and it is my responsibility to know the terms of the policy. I further acknowledge that any insurance payments authorized to be paid directly to my provider will be credited to my account. I ALSO AGREE THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY REMAINING BALANCE ON MY ACCOUNT (DEDUCTIBLE, COPAYMENTS, ETC) AND UNDERSTAND THAT PAYMENT OF THE CHARGES ARE DUE AT THE TIME OF SERVICE.

If your insurance carrier has not responded to a claim in 45 days, we reserve the right to formally transfer all associated liability for the claim to you. Failure to promptly resolve this balance may result in third party collection and/or legal action.

If I default, the guarantor is responsible for any fees and costs from past due accounts turned over to a collection agency and/or attorney. These fees included 35% of the unpaid balance and a $10.00 handling fee.

I agree to pay all reasonable collection and court costs, attorney's fees and all other lawful charges incurred in connection with collecting indebtedness to my provider.

For your convenience, cash, check, money orders, debit cards, Visa and MasterCards are accepted means of payment. Returned or NSF checks will incur a $45 fee, and your provider may decline to accept a check as payment for future charges.

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Print Name of Patient

_____ _____

Signature of Person Responsible for Payment Date