

FINANCIAL AGREEMENT

I, _____ (patient), understand that the no fault insurance is an agreement between the insurance company and myself. I understand that Tracy Bell, health care provider, will assist me in billing my insurance carrier for services provided to me. However, I am fully responsible for any payments due that are denied by my insurance company. I assign payments to be made on my behalf to this provider for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services. If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the balance on the sixty-first (61st) day. In the event fees are not paid as requested, I hereby authorize the health care provider to charge all past due payments to my credit card listed below. I understand that upon payment I will receive a receipt for submission to my insurance company for reimbursement. In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I _____ (client), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

Signature: _____

Credit Card Number: _____ Expiration Date: _____

Name of Cardholder as it Appears on Credit Card: _____
