STATEMENT OF ACCOUNT

Patient Name _____

Individual Responsible for Account _____

Social Security Number _____/_____/_____

Home Address_____

City, ST, Zip code _____Telephone_____

Employer_____

Business Address_____ Telephone_____

In consideration of professional services rendered or to be rendered I, _____, agree to pay my account in accordance with the following terms:

PAYMENT DUE WHEN SERVICES ARE RENDERED

Account payments are due on the lst of each month. All account balances unpaid in 30 days will be charged a monthly handling fee of 1-1/2% (annual percentage rate of 18%). Payments will be expected as arranged above. Default in payment of installment shall cause the entire balance to be due and payable on demand. Failure to exercise this option shall not constitute a waiver of the right to exercise the same in the event of any subsequent default or late payment.

In case it becomes necessary to seek collection resources due to default or late payment, all reasonable attorney's fees and other costs of collection will be in addition to the existing account balance.

Primary account responsibility will be with the patient or individual responsible for the account.

Signature_____ Date _____

Co-Signature_____ Date _____

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