OST

New Patient Fee Agreement

I _____ acknowledge that until I provide proof of insurance (i.e. an insurance card, active plan identification number, or a complete claim form), I will be considered a cash patient. I understand that I am responsible for all incurred fees that are not covered by my insurance plan. If the claim is denied because I neglected to bring a required referral or because the procedure is not a covered benefit under my policy, I recognize that I am obligated to remit the remaining balance.

I understand that if I cancel or reschedule my surgery appointment within 48 business hours of my procedure date/time, I am responsible for a last-minute cancellation fee of $50 per every 30 minutes of any surgical appointments (60 min scheduled surgery = $100 fee).

All accounts 60 days past due will accrue a service charge at the rate of 18%APR. In addition, should my account become delinquent, it is my understanding that I will also be responsible for all collections cost (50%) and attorney fees (40%). There is a $35 charge for all returned checks.

_____	_____	_____
Signature of Responsible Party	Printed Name of Patient	Date