WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

- **Cash Patients:** Payment is due when services are rendered. We gladly accept MC, Visa, Discover, or check /cash.

- **Massage**: Please be aware, anyone failing to give 24 hour notice to cancel a massage appointment or failure to show for a massage appointment will be charged a $20 fee for an hour massage. (This applies to both Insurance and Time of Service Patients.)

- **Insurance Patients:** Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full, immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual or Group Insurance policies, Personal Injury claims, authorized Worker's Compensation and Medicare.

- **Collection/Attorney Fees:** I agree to pay all costs of a collection agency if necessary to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

- **Authorization to Process Drafts:** I agree that Figa HealthCare PLLC shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

- **Limited Release of Medical Information:** I authorize FigaHealthCare PLLC to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these assignments.

- **Assignment of Cause of Action:** In the event that any insurance company or other third party obligated to make payment to me or to FigaHealthCare PLLC for the charges made for the services, refuses to make such payment upon demand, I hereby assign, transfer and convey to Figa HealthCare PLLC any and all cause of action that might exist in my favor against any such company or person. I authorize Figa HealthCare PLLC to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

- **HIPAA Policies and Procedures** I have read and understand the HIPAA Policies and Procedures for Figa Healthcare, PLLC.

Responsible Party Signature_____ Date: _____

Print Name_____