ADVANCED
HAND & PLASTIC SURGERY CENTER

Occupational/Hand Therapy
Self-Pay Financial Agreement

Patient's Name	Last:	First:	Middle Initial:
Financially Responsible Party (if different)	Last:	First:	Middle Initial:

If you do not have health insurance and have decided to be treated by our Certified Hand Therapist, at Advanced Hand & Plastic Surgery Center, LLC you are responsible for following our "Self-Pay" policy:

1. You are responsible for payment of services provided to you and are required to pay an estimated amount of anticipated services and treatment prior to the initial consult, and the actual amount due at check-out after the appointment, on the same day of every visit.
   _____Please Initial
2. If you do not pay in full the actual amount, any subsequent visits are rescheduled until your account balance is paid in full.
   _____Please Initial
3. If you are not able to pay your balance in full for services rendered, please contact our billing department immediately to discuss payment plan options, if any. You can not continue treatment if an outstanding balance remains on your account prior to the next scheduled appointment.
   _____Please Initial
4. Your cooperation in canceling your scheduled appointment allows us the opportunity to offer your time slot of 45 minutes to a person who needs to be seen by the therapist for treatment. Failure to keep your scheduled and confirmed appointment will result in a **$25 cancellation fee**, due along with any other charges at the next scheduled visit.
   _____Please Initial

I, _____("patient/financially responsible party"), agree to the following financial agreement with Advanced Hand & Plastic Surgery Center, LLC. I agree to pay for services and/or treatment out-of-pocket as outlined in the "Self-Pay Rate Fee Schedule*" at the time services are provided by the certified hand therapist. I understand that I am responsible for any and all additional fees services agreed to as described in the "Fee schedule." Furthermore, I understand that failure to make payment as stated in our self pay policy for services rendered that go unpaid for more than 30 days will result in financial penalties, such as, but are not limited to, collection and legal fees.

My signature below constitutes acknowledgement and acceptance of this financial agreement between Advanced Hand & Plastic Surgery Center, LLC and myself.

Responsible Party Signature: _____Date: _____

Patient's Name-(printed):_____

Reviewed by (OT/billing only):_____ _____Date:_____

**Note: A copy of the payment self-pay fee schedule for your records, furnished upon request.* *Approved: 04/25/12*