OFFICE POLICIES

FINANCIAL AGREEMENT:

The undersigned agrees he/she is hereby obligated and agrees to pay Phanord & Associates, PA charges for services rendered by said Doctor. I further agree that payment is due of day of service. I understand that unpaid accounts will be considered in default after thirty (30) days, after which time interest will be imposed at the rate of 1 ½ % per month on unpaid balances (ANNUAL PERCENTAGE RATE OF 18%) or the legal interest rate of, whichever is lower. In the event of legal suit or outside collections are necessary to enforce payments on this account, I agree to pay 25% of the principal's balance for attorney's fees and court costs or 30% collection fees. The patient/guarantor waives venue jurisdiction and submits itself to the jurisdiction and venue of the State Courts of Dade County, Florida.

ASSIGNMENT OF BENEFITS:

I hereby authorize payment to be made directly to Phanord & Associates, PA for benefits which may be due and payable under insurance coverage for the said patient. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under the title XVII or XIX of the Social Security Act is correct, and requests that said payment of authorized benefits be made payable on my behalf to Phanord & Associates, PA. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of the benefits does not I any way relieve me of liability and that I will remain financially responsible to Phanord & Associates, PA

AUTHORIZATION TO RELEASE MEDICAL RECORDS INFORMATION:

In compliance with HIPAA regulations, Phanord & Associates, PA is hereby authorized to disclose all or any parts of the medical/dental records of said patient to such insurance companies, organizations, or agencies as may be responsible for payments of services rendered by Phanord & Associates, PA. Likewise, my insurance company, organizations or agencies responsible for payment is hereby authorized to disclose all or any part of the medical/dental records to Phanord & Associates, PA, which include treatment for Drug and Alcohol Abuse, Mental Health, HIV Virus and Sexual Assault. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by Phanord & Associates, PA.

MISSED APPOINTMENTS:

An appointment is broken when the office does not receive a courtesy call at least 24 hours before the scheduled appointment advising of a cancellation. A fee of $15 per ½ hour schedule appointment will be assessed if broken. If more than one (1) appointment is broken in a 6 month period, no future appointments will be given for the next 6 months.

X-RAY EXAMINIATION (FOR FEMALE ONLY):

I am aware that the radiation exposure may be harmful to an unborn child. To the best of my knowledge, I am not pregnant at this time. I agree to a diagnostic x-ray examination as requested by Phanord & Associates, PA.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS EACH OF THE ABOVE PARAGRAPHS AND IS THE PATIENT OR RESPONSIBLE PARTY WITH THE POWER TO EXECUTE THIS DOCUMENT AND ACCEPTS THESE TERMS.

_____ _____ _____

Signature of Patient/Responsible Party Signature of Office Staff Date