FOLLMAN AGENCY FINANCIAL AGREEMENT

DATE: _____ **NAME:** _____ **DOB:** _____

I hereby agree to immediately advise the FOLLMAN AGENCY of any changes in:

1. Change of address/phone number
2. Insurance Coverage
3. Employment Status

I hereby agree to pay all fees for services currently or previously rendered by the Follman Agency. I understand the full monthly payment must be made on my account by the 20th of every month or my account will be subject to a $10.00 late payment fee. Also, I am aware that I will be suspended from treatment immediately if payment is not made. I will contact the Follman Agency to reestablish a payment schedule or services may be discontinued until payments are current. In the event of default of payment, I will be held liable for the unpaid balance, including any attorney or collection fees permitted by law. I understand accounts 90 days past due will be sent to collections (SB&C, LLC).

I understand my records are protected under the Federal and State Confidentiality Regulations and cannot be *disclosed without my written consent unless otherwise provided within the Regulations. I also understand I may* revoke this consent at any time except to the extent action has been taken in reliance on my account (i.e., probations, courts, etc.) and in any event this consent will expire when my account is paid in full.

RELEASE OF INFORMATION: I authorize the Follman Agency and/or the Insurance Company to release any information required to process claims.

RELEASE OF BENEFITS: I hereby authorize my Insurance Benefits to be paid directly to the Follman Agency.

TREATMENT PROGRAM: _____

PROGRAM CHARGES:

Down Payment	Monthly Payment	Program Cost
$350.00 Down Payment		

I agree to pay the Follman Agency in monthly installments of $ _____ per month until the fee of $_____ is paid in full. I agree to make a down payment of $_____, which shall be applied to the end of my payment schedule.

_____

Patient Signature Above Line (Please Print Clearly Below)