FOLLMAN AGENCY FINANCIAL AGREEMENT

DATE:_____NAME:_____DOB:_____

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

- Address/Phone Number
- Insurance Carrier/Plan/Coverage (Please Provide Copy of New Card)
- Employment Status
- Email Address

I hereby agree to pay all fees for services currently or previously rendered by the Follman Agency. I understand the full monthly payment is due the first of each calendar month. Follman Agency gives a 20-day grace period. If payment is not received by the 20th of each calendar month, your account will be subject to a **$25.00** 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.

TREATMENT PROGRAM:

PROGRAM CHARGES: $350.00 DOWN PAYMENT REQUIRED AT INTAKE APPT.	**_____ MONTHLY PMNT**	**UNTIL $ _____ IS PAID IN FULL**

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 $350.00, which shall be applied to the beginning of my payment schedule.

_____

Patient's Signature Date