



## Financial Agreement

I authorize the payment of all insurance benefits to PCA. I agree that I am responsible for all co-pays, non-covered services and balances not covered by my insurance. I understand 18% interest may be charged on all past due accounts I owe. I agree that I may incur 5% late fees on past due balances I owe. I authorize the release of pertinent medical information to third parties and/or insurance carriers to obtain payment for services rendered. I understand that if I do not have proof of insurance or the necessary authorization that I am responsible for all charges. If I have a delinquent account that is turned over for collection, I agree to pay attorney fees equal to 25% of the principal balance owed in addition to the account balance, late fees and interest due. This agreement shall be legally binding to all services rendered and to any previously unpaid services of PCA.

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Patient name (Printed)

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Signature

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Date

Revision date 8/25/2010

Patient Account # \_\_\_\_\_

Copy sent to Collections Department on \_\_\_\_\_ by \_\_\_\_\_  
(Date sent) (Front office employee name)