GOOD MEDICINE FINANCIAL POLICY

This is an agreement between Good Medicine a California Professional Corporation, as Creditor, and the patient/Debtor named on this form. By signing this agreement, you are agreeing to pay for all services that are received. Including services not covered or denied by your insurance company.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, copays, covered charges, secondary insurance, etc, other than to supply factual information as necessary or requested by your insurance company.

Payments: All copays and deductibles are **due at the time of service** unless other arrangements are approved by us in writing. The balance on your statement is due and payable when the statement is issued and is past due if not paid by months end. A finance charge of 1.5% (18% APR) will be imposed on each charge for any balance exceeding 30 days. All payments received from you will be applied to satisfy the finance charges before being applied to your owed balance. Your account balance will be sent to collections if not paid in full within 90 days.

Payment options: We accept cash, check, visa and master card. By signing here you are allowing Good Medicine to bill your credit card for any balances owed.

Credit card#_____ Exp date:_____

Signature_____Zip Code_____

Returned checks: There is a $25.00 fee for any checks returned by the bank.

Workers Compensation: We no longer accept any workers compensation claims.

Medicare: If you receive services which are not a Medicare benefit, you agree to pay for those services in full.

Missed appointment: A 24 hour notice of cancellation is required. First missed appointment will result in notification by our office via phone or mail. Second missed appointment will result in fees pertaining to the length of your appointment, i.e. $75 for office visit, $150 for procedures or physicals (Comprehensive Medical Exam, yearly wellness exam or Medical Clearance exam). Third missed appointment and failure to pay this fee will result in termination of your care.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

_____ _____

Responsible Party's Signature Date

Rev. 7/16