PAYMENT AGREEMENT

THE INTENT OF THIS AGREEMENT IS TO FOSTER AND MAINTAIN A PLEASANT, PROFESSIONAL RELATIONSHIP WITH OUR PATIENTS BY MINIMIZING MISUNDERSTANDINGS CONCERNING FEES AND OTHER COSTS.

ALL FEES, COSTS AND EXPENSES ARE DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE AND DOCUMENTED PRIOR TO YOUR APPOINTMENT.

IN THE EVENT THAT A PATIENT HAS INSURANCE COVERAGE, ALL INSURANCE BENEFITS ARE HEREBY ASSIGNED UNTO NCCRM AND THE INSURANCE COMPANY IS INSTRUCTED TO PAY THE BENEFITS DIRECTLY TO NCCRM. NCCRM HAS AUTHORIZATION TO RELEASE AND PROVIDE TO THE INSURANCE MEDICAL INFORMATION AND RECORDS, SHOULD THEY BE REQUESTED.

IT IS THE EXCLUSIVE RESPONSIBILITY OF THE PATIENT TO DETERMINE WHETHER ANY PROCEDURE IS COVERED BY INSURANCE AND NO STATEMENTS MADE BY ANY AGENT OR EMPLOYEE OF NCCRM WILL BE CONSTRUED TO REPRESENT THAT COVERAGE IS AVAILABLE. THE UNDERSIGNED PERSON/S WILL BE RESPONSIBLE FOR ANY PORTION OF A BILL NOT PAID BY THE INSURANCE COMPANY.

FOR ANY CHECK THAT IS RETURNED FOR ANY REASON, A $40 RETURNED CHECK FEE WILL BE DUE.

IN THE EVENT THAT YOU ARE UNABLE TO MAKE YOUR APPOINTMENT, A 48 HOUR COURTESY PHONE CALL IS REQUIRED OTHERWISE YOU WILL BE BILLED A $50 NO SHOW FEE.

THE UNDERSIGNED PERSON/S AGREE TO PAY NCCRM ALL COSTS OF COLLECTIONS, INCLUDING BUT NOT LIMITED TO COURT COSTS AND REASONABLE ATTORNEY FEES INCURRED TO COLLECT THE AMOUNTS DUE.

THIS AGREEMENT WILL BE INTERPRETED ACCORDING TO THE LAWS OF THE STATE OF NC.

THE UNDERSIGNED PERSONS ACKNOWLEDGE HAVING READ THE ABOVE TERMS AND AGREE TO PAY ALL FEES AND CHARGES IMPOSED ACCORDINGLY.

PATIENTS PRINTED NAME	DATE OF BIRTH
PATIENTS SIGNATURE	DATE
SIGNIFICANT OTHER PRINTED NAME	DATE OF BIRTH
SIGNIFICANT OTHER SIGNATURE	DATE