



THIRD PARTY PAYER AGREEMENT

I accept full financial responsibility for the treatment of _____ and agree to the provisions of the enclosed financial agreement.

Please select one of the following options for payment of _____'s treatment. Please initial by the option of your choice.

Please indicate preferred method	Payment Options
	Credit card payment: You may provide the client with a credit card to present at the time of service or we can manually enter your credit card information (credit card number, expiration date, and billing zip code).
	Payment at the time of service: You may provide the client with cash or check to remit when they come in for their appointment. If, for whatever reason, the client runs a balance, you will need to provide a credit card number we can maintain on file.

You may elect to have a statement sent to you at the beginning of each month. The statement will reflect all payments you made for the previous month.

If you would like a statement sent to you, please indicate your address:

If you have any questions or concerns please contact our Accounts Receivable Manager.

Signature

Date

Print Name

Date