

**FINANCIAL POLICY FOR
DR.DANIEL T. ZAHARI**

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED A PART OF YOUR TREATMENT. THE FOLLING IS A STATEMENT OF OUR FINANCIAL POLICY WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO ANY TREATMENT.

**FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA AND MASTER CARDS
ALL CO-PAY AND DEDUCTIBLES ARE DUE AT THE
TIME OF SERVICE.**

----USUAL and CUSTOMARY RATES----
OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT IS USUAL AND CUSTOMARY FOR OUR AREA. YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

----ADULT PATIENTS----
ADULT PATIENTS ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.

----MINOR PATIENTS----
THE ADULT ACCOMPANYING A MINOR AND THE PARENTS (OR GUARDIANS OF THE MINOR) ARE RESPONSIBLE FOR FULL PAYMENT. FOR UNACCOMPANIED MINORS, NON-EMERGENCY WILL BE DENIED UNLESS CHARGES AND TREATMENT HAVE BEEN PRE-AUTHORIZED TO THE APPROVAL OF OUR OFFICE.

IF YOUR ACCOUNT BECOMES SERIOUSLY PAST DUE YOU WILLNO LONGER BE ABLE TO BE SEEN IN OUR OFFICE ,UNTIL YOUR BALANCE IS PAID IN FULL.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS. I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X _____ DATE _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PRINT NAME