CURTIS TAKEMOTO-GENTILE, MD

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Please note that this agreement states your financial responsibility as a patient of Curtis Takemoto-Gentile, M.D. Inc., and addresses the possibility of incurring out of pocket expenses.

Insurance Claims/Payment: (please initial) _____

As a courtesy, Curtis Takemoto-Gentile MD Inc. will file an insurance claim for you; however, in the event that your insurance company denies payment for any reason or has not paid within 45 days, you or the guarantor will be responsible for any balance due. It is also your responsibility to provide current address, billing information and insurance information by carrying an updated insurance card and by following up on any issues with the insurance carrier and billing issues. We are a medical care provider; our relationship is with the patient and not with the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date of service rendered**.**

Cash Services: (please initial) _____

Some services provided by Curtis Takemoto-Gentile M.D. Inc. are considered alternative treatments that are not covered by any insurance and will not be billed to your insurance carrier. All supplements and cash service charges (i.e. IV therapy, laser treatments, etc.) will be collected at the time of service.

Patient Account Charges and Statements: (please initial) _____

Co-payment and/or any balance due payments on your account are requested at the time of your scheduled visit; we accept cash, check, and credit card. If you have no insurance plan, you will be required to pay 100% of the visit charges at the time of your visit. You may contact our billing specialist to arrange and sign a monthly payment plan agreement if necessary.

Collections: (please initial) _____

If your account is over 90 days old with no payment activity, it will be transferred to a collection agency. A $35.00 fee will be added to your account upon transfer. This may include, but is not limited to, attorney's fees and other costs that Curtis Takemoto-Gentile, M.D. Inc. considers necessary. To avoid collections, please be sure to pay your co-payment at the time of your visit or mail in your payments within one month of receiving your statement.

Returned Checks: (please initial) _____

All returned checks will be subject to a $25.00 NSF fee. You will be required to pay the original amount in addition to the $25.00 NSF fee before being seen for another appointment. As a result, you may be placed on a cash/credit card only payment method for future appointments.

Receipts and Invoices: (please initial) _____

Our patients are responsible to track all receipts for supplements and other cash services. Our computer system does not provide statements for such services. Any such requests will be subject to a $25 fee/page.

No Show and Cancellation Charges & Late/Rescheduling Fees: (please initial) _____

As a courtesy to our physician, staff, and other patients, we ask that you cancel your appointments at least 24 hours in advance. There is a $50.00 fee for not showing up or for canceling with less than 24 hours notice. True emergencies will be handled accordingly with the office manager.

Please note that any patient arriving 15 minutes or later after their scheduled appointment time may be rescheduled and charged a $25 fee. (please initial) _____

Credit Card Payment Authorization (Optional):

We request that your credit card information be on file with us to process any outstanding balances on your account. Our billing specialist will notify you before any transactions are made and will mail a receipt to your billing address.

Card Type: Visa / Mastercard / Debit (circle one) Card number: _____

Name on card: _____ Exp Date:_____ CVV Code:_____

By signing below, you are agreeing to and understand the above financial agreement and you acknowledge that as the patient and/or guarantor you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

Signature:_____ Date: _____

Print Name:_____ DOB: _____