

**Terry Allen MD & Scott Forrest MD, PLLC**  
**Financial Agreement**

I, the undersigned, hereby agree to pay Terry Allen, MD and Scott Forrest, MD, PLLC all fees due for services rendered and/or expenses incurred by me, my spouse, or my children/dependents. Payment is to be made at the time of service or incurring of expenses.

I understand that the payment of my bill is my legal obligation as the patient. All filings of insurance papers, confirmation of eligibility of benefits, and/or confirmation of insurance payments to be made by my insurance company are my responsibility. Any assistance in this matter granted by Terry Allen, MD and Scott Forrest, MD, PLLC is given strictly as a courtesy and implies no responsibility on their part for filing, follow through, or confirmation.

If my account is placed in the hands of an attorney for collection, I agree to pay attorney fees of thirty-three and one-third (33 1/3) percent of the unpaid principle plus all court costs that are accrued in the collection process. I also agree to pay interest in the amount of one and one-half (1 1/2) percent per month beginning 90 days after the bill has become due. In the event a payment plan is in place and the account is in default, the interest at the above rate will begin on the default date and the account balance will become due immediately, including the costs of collection.

I also agree to the following administrative fees may be applied to my account:

\$20 fee per returned check

\$20 fee for the copy of medical records under 50 pages

\$20 fee plus 25 cents per page for the copy of medical records over 50 pages

\$20 fee for each after-hours emergency telephone prescription (new or refill)

\$20 fee for a missed appointment when a cancellation notice of at least 24 hours is not given

\$10 fee for the completion of a disability or medical leave form

**Attestation:**

I acknowledge, understand, and agree to the terms herein and also agree that these terms are reaffirmed each time services are received.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_