

# NOTICE

I, \_\_\_\_\_ understand that payment is due when services are rendered. On occasion bills will be sent after the patient has been dismissed. If you do receive a bill, it must be paid in full within thirty days of the billing date. Failure to do so may result in the account being sent to collections.

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

Furthermore, if full payment is not received within ninety days of the billing date, the account will be turned over to collections. Client agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 40%. Such contingency fees will be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

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

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_