IN ORDER TO CONTROL COSTS, IT IS REQUIRED THAT PAYMENT BE MADE AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE

Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is my responsibility to pay the deductible amount, co-insurance, or any other balance not paid by my insurance. Even though, as a courtesy, the office has sent an insurance claim, I understand that I will receive a statement of my account if there is an outstanding balance. I further understand the doctor cannot accept responsibility for collecting my insurance claim or negotiating a settlement on a disputed claim; and that I am responsible for the timely payment of my account and for all delinquency charges resulting from a failure to pay the account promptly. If this account is assigned to an attorney for collection/and or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection.

I understand that Drs. Allen and Carol Stark will not be filing insurance claims to any out-of-network insurance company, and that if I am insured by any of these, I am responsible for paying the full fee at time of service.

Please Initial _____

I UNDERSTAND I WILL BE CHARGED FOR ANY MISSED APPOINTMENTS OR CANCELLATIONS WHERE ONE FULL BUSINESS DAY'S ADVANCE NOTICE HAS NOT BEEN GIVEN.

Please Initial _____

I UNDERSTAND THE FEE FOR ANY MISSED 30-MINUTE APPT IS $125

Please Initial _____

I UNDERSTAND THE FEE FOR ANY MISSED 45-MINUTE APPT IS $150

Please Initial _____

Patient: _____ Date _____

Responsible Party _____ Date _____