PAYMENT ARRANGEMENT FORM

PATIENT NAME: _____

ADDRESS: _____

PHONE #: _____ DOB: _____

ACCOUNT # _____

PROCEDURE ORDERED: _____

MEDICALLY NECESSARY INFORMATION: _____

_____

_____

_____

Email this form along with any copies of orders to your financial counselor. Once the Financial Counselor has completed the form it will be emailed to the Clinic Director.

Please note, Financial Counselors DO NOT make clinical decisions. If there is a question in response to the medical necessity, the information will be returned to the Clinic Director and for discussion with your physician requesting they verify medical necessity.

DEPOSIT AMOUNT: _____ DATE RECEIVED: _____

PAYMENT ARRANGEMENTS: _____

FINANCIAL COUNSELOR NOTES: _____

_____

PATIENT SIGNATURE: _____ DATE: _____

FINANCIAL COUNSELOR SIGNATURE: _____