

**Scott R. Rigden, MD, PC**  
**Janet E. Tatman, PhD, PA-C**

**FINANCIAL AGREEMENT**

I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement or I make a different agreement with Dr. Tatman or with Dr. Rigden's office.

**Professional Fees:**

**My initials below indicate that I have read and agree with each item.**

- \_\_\_\_\_ Any co-payment is due in full at time of service.  
\_\_\_\_\_ Special financial arrangements must be discussed at the first appointment.  
\_\_\_\_\_ Parents/Guardians are financially responsible for payment for service provided to minors or others in their legal care.  
\_\_\_\_\_ A \$25 processing fee will apply for any returned check.  
\_\_\_\_\_ A fee schedule is available upon request.  
\_\_\_\_\_ Fees may include charges for other professional services such as
1. Report writing
  2. Telephone conversations
  3. Consulting with other professionals
  4. Preparation of records or treatment summaries
  5. Legal proceedings, including preparation time and transportation
  6. Above fees will be discussed in advance

**Insurance Benefits:**

**My initials below indicate that I have read, understand, and agree with each item.**

\_\_\_\_\_ It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the relevant sections in my insurance coverage booklet. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered by my insurance plan.

\_\_\_\_\_ I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self-pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

\_\_\_\_\_ I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided as a courtesy to me, but I remain the responsible party.

\_\_\_\_\_ I understand that, if after 90 days, my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

**Policy for Missed Appointments and Cancellations:**

**My initials below indicate that I have read and agree with each item.**

\_\_\_\_\_ I agree that I must give proper notification to cancel an appointment to avoid any late cancellation or no show fees. I agree to call at least **24 hours** in advance to cancel or change my appointment. For Monday appointments, I will call the previous **Friday by noon** to cancel or change an appointment to avoid any late cancellation or missed appointment fees.

**I HAVE READ THIS FINANCIAL AGREEMENT, ASKED AND HAVE HAD ANSWERED ANY QUESTIONS I HAVE ABOUT IT, AND AGREE TO ITS TERMS.**

\_\_\_\_\_  
Patient or (Authorized Parent/Guardian Name)      **Printed**

\_\_\_\_\_  
Patient or Authorized Parent/Guardian      **Signature**

\_\_\_\_\_  
**Date Signed**