Financial Policy

1. I am responsible for payment of all services rendered on my behalf and my dependents; regardless of any insurance benefits I may have.
2. I have been informed that payment is due when services are rendered.
3. I understand that my insurance policy is a contract between **myself and the insurance company**, and that Dr. Yoon's office is in no way a part of that contract.
4. Any balance owed on my account is subject to interest at a rate of 1.5% monthly.
5. Should my account become delinquent and turned over to our collection agency, I will assume all additional collection costs at 30% and any additional legal fees.
6. A $50.00 broken appointment fee will be charged on all broken appointments or last minute cancellations. I am aware that a 24 hour notice of cancellation is required. _______ (please initial)
7. I have read the above information. I have had the opportunity to have any questions answered. I fully understand my obligations.

Signature of Patient/Responsible Party____

Date____________________________________