2. Insurance Patients: we will bill your insurance carrier as a ***courtesy*** to you, though there may come a time when we require you to take an active part in the recovery of any claims.
3. All cash patient fees, insurances deductibles and co-insurance payments are due at the time of service.
4. Our office accepts payments in the form of cash, check, credit card (VISA/MASTERCARD/DISCOVER) and money order.
5. Returned checks will be subject to an additional fee of $25.00. This office reserves the right to deny payment by check after a returned check has occurred and ask the patient to pay in full using cash, credit card or money order.

Patient balances over 30 days past due will be subject to an interest charge of 1.5% per month.

I _____agree that I am responsible for any collection cost including but not limited to any attorney fees (minimum of $350.00) and court costs that may be incurred by Pasadena Neck and Back Pain Center L.L.C.

I, _____ hereby waive any statute of limitations, which might affect any claim(s) that Pasadena Neck and Back Pain Center LLC may have against me.

I, _____ understand that SEAL after my signature extends the statute of limitation to 12 years regarding any balance owed to me.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____