FINANCIAL POLICY

All patients are financially responsible To Drs. Sadr and Kooshki for all of the charges incurred by themselves and/or their dependents. In the event this account is turned over to an attorney for collection, the undersigned agrees to pay collection fees equal to 35% of the unpaid principal, plus interest on accounts, beginning 30 days after the monies have become due, at the rate of 24% per annum.

We reserve the right to charge $30.00 per half hour for broken appointment without 24 hours advance notice, and there will be a charge of $30.00 for any returned or dishonored checks.

Patient's Signature (Parent's if minor) _____ Date _____

IF YOU HAVE INSURANCE THAT YOU WISH US TO FILE, THEN PLEASE READ AND SIGN

I hereby assign all medical, dental and /or surgical benefits to which I am entitled for this service to Drs. Sadr/ Kooshki. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any and all remaining balance of my and/or my dependent's account not paid by said insurance within 30 days. I hereby authorize the release of all information necessary to secure payment.

Patient's Signature (Parent's if minor) _____ Date _____