



## FINANCIAL POLICIES

Please take time to read and sign this financial responsibility statement before your first visit.

### PAYMENT POLICY:

All account balances are due at the time of service. We reserve the right to not extend credit, as this is not a service we guarantee. We accept cash, checks, MasterCard, and Visa.

### INSURANCE POLICY:

We do not accept insurance at this time. We do not offer billing services for insurance companies.

**INTEREST FEES:** There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to a monthly finance charge of 2.0% of the unpaid balance, which is an annual percentage rate of 24% (or a minimum charge of \$1.00).

### MISSED / LATE CANCELLATION APPOINTMENT FEES:

We require 24 hours notice for rescheduling or canceling patient appointments.

We may charge for missed appointments, or appointments not canceled or rescheduled within the 24 hour time frame as stated above a fee of \$100.00.

### ACKNOWLEDGMENT:

I have read this financial policy statement and understand its terms. I understand that delinquent accounts may be assigned to a credit reporting collections service. If it becomes necessary to pursue collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney

fees. There will be a \$50.00 fee added to any accounts referred to collections. I hereby authorize the Maui Regenerative Medicine to release any information necessary to secure payment.

Print Patient's Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Responsible Party Relationship to patient \_\_\_\_\_ SSN# :

\_\_\_\_\_



Signature of responsible party Date \_\_\_\_\_