

**Patient Bill of Responsibility**

This office is committed to giving our patients the best care possible.  
 As a patient of Dr. Draper and Dr. Lindstrom, I agree to the following:

- I agree to pay all co-payments and/or deductibles that are due, at the time of service.
- If I do not have insurance, I agree to the "Self Pay Policy":

**Self Pay Policy:**

20% discount if paid in full at time of service

Or

1/3 down on date of service and 90 days to pay in full.

If no payment is received in 60 days there will be a \$25 late fee

\$25 fee if no payment after 90 Days.

After 90 days you will be sent to collections and incur a 35% collection fee.

- As a courtesy, we will submit charges to your insurance but the patient is ultimately responsible for payment.
- I agree to be on time to my appointments, if I am 10 minutes late I will reschedule.
- I will give 24 hour notice if I need to reschedule my appointment.

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Patient or responsible party Signature      Date      Witness

