CUSTOM FIT THERAPIES
JULIE A. VENN, L.M.P., MLD/CDT

101 5th Street NE Auburn, WA 98002
Phone 253.288.8835 FAX 253.288.9621

Financial Agreement

As a courtesy, we will bill your insurance company for treatment and/or Durable Medical Equipment (compression garment, etc.)

Coverage will be verified with the insurance company. Eligibility and payment is the responsibility of the patient.

It is necessary to keep all scheduled appointments with the practitioner/ fitter. If I fail to appear for a scheduled appointment or cancel a scheduled appointment with less than 24 hours notice, I understand that I will be charged and responsible for a no show or late cancellation fee. A $70 fee is based upon the amount of time allowed in the practitioner/fitters schedule for this appointment.

Payment Agreement (please initial appropriately)

Without Insurance
_____ I agree to keep my account balance current by paying cash at each visit.

With Insurance
_____I will assume responsibility for keeping my account current.

_____ I understand that the practitioner/fitter will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the practitioner/fitter will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to myself are charged directly to me and that I am personally responsible for payment. Should this account be turned over to collection for any reason, under provision of Washington State Law R.C.W. 19.16.250 January 1984, reasonable collection costs of 30-55% may be added to accounts requiring such third party expenses. An accounting service charge of 3% will be added to accounts over 60 days past due.

_____ _____
Signature Date

_____
Please print