Agreement addendum:

I accept responsibility for any charges associated with this and all visits. I understand that I must present my insurance card and photo identification at each visit or my appointment will be rescheduled.

I understand that I must give at least a 24 hour notice if I am unable to make it to any of my appointments. I understand that if I fail to cancel it ahead of time a $25 fee will be charged to my account.

I understand if I fail to show up for an appointment, a $25 fee will be charged to my account.

I understand that once my insurance company has processed my claims I am responsible for the balance due. If I do not make a monthly payment on my balance, I will be charged a $30 monthly fee.

I also understand that if my account is past due over 120 days, and I have not made arrangements for monthly payments, that late fees may be added to my account and if my account is send to a collection agency, a $30 fee will be added to my account.

My signature on this form covers all dates of service and charges I incur with USAAJJ Medical from this day forward.

_________________________________ _________________________

Patient Signature Date