Child's Name: _____ Date of Birth: _____

Parent or Guardian Name: _____

Financial Agreement

Please initial to indicate your acknowledgement and agreement

_____I understand that my insurance policy is an arrangement between my insurance company and myself.

_____I understand that the information NOAC received on my coverage is NOT a guarantee of payment and may change at any time.

_____I understand that it is my responsibility to verify all insurance coverage and information.

_____I agree to be responsible for payment of all services rendered on my behalf or that of my dependent that is not covered or is denied by my insurance company.

_____I agree to be responsible for paying all of my deductibles, co-pays and coinsurance.

_____I agree to update NOAC in the event of any changes to my insurance status, as soon as they occur.

_____I understand that a $30 cancellation fee may be billed to my account if I do not contact NOAC with at least 24 hours of a cancellation.

_____I understand that I may be discharged from NOAC if more than 20% of scheduled session are not attended per quarter.

_____I understand that payment plans are available at my request.

_____I understand that my subscriber responsibility will be automatically billed at the end of each month.

_____I understand that I need to maintain an active credit card on file for automatic billing at the end of each month for my subscriber responsibility.

_____ _____ _____

Patient or Legal Guardian Signature | Patient or Legal Guardian Print | Date