FINANCIAL AGREEMENT with Dr. Caroljean Bongo PsyD LLC

This agreement states that I _____understand that any amount unpaid by my insurance company is my responsibility, regardless of any statements made by my insurance company when my benefits were verified. There are no guarantees that the expected out of pocket expense amount provided by my insurance company is correct, as the amount could be higher or lower.

I am also aware that if my insurance company(s) do not pay Dr. Caroljean Bongo as expected, I am responsible for the unpaid balance.

By signing this agreement, I also acknowledge that I am aware that services of a collection agency to collect on delinquent accounts will be utilized. This will require the release of identities to American Collection Systems Inc (Laramie WY). At this point, I understand that my account will begin to accrue 21% interest that will be my responsibility AND ADDED TO MY BALANCE DUE. Should my account be referred to an attorney for collection/legal action, I agree to pay reasonable attorney fees and court costs. Returned check fees charged to Dr. Bongo will also be my responsibility.

Before submitting my balance due to a collections agency, an attempt to contact me by phone will be made and a message will be left. Should I choose not to return the call or make payment, I am aware that my account will be turned over to collections.

I am aware that the use of a collections agency is something Dr. Caroljean Bongo would prefer to avoid, but will utilize when no payment or explanation is provided. Monthly payments are accepted in the event payment in full isn't possible.

_____ _____

Signature of financially responsible person Date

Cc: Psychiatric Billing Associates Inc.