Cordell Associates, LLC
6500 Poe Avenue, Suite 400
Dayton, Ohio 45414
937-276-3356 (phone)
937-276-9514 (fax)

FINANCIAL AGREEMENT
Standard

CLIENT NAME____

PRIMARY INSURANCE_______________________________________

PHONE # FOR BENEFITS_____________________________________

NAME ON POLICY :__________________ SS#:____________________

PLACE OF EMPLOYMENT:____________________________________

AUTHORIZATION REQUIRED?_________

DEDUCTIBLE?______________

CO-PAY?____________ YEARLY MAX FOR BENEFITS?_______

________I will pay my co-pay of $_________at the time of each visit as expected.
Initial

________Any other arrangements need to be discussed and agreed upon with the
Initial office manager prior to or at the first appointment.

DIVORCED PARENTS

_______The parent requesting treatment in our office is responsible to pay the bill.
Initial Any co-pays or deductibles that need to reimbursed to you from the other parent are your responsibility to collect.

____________________________________ ____________________________
Signature of responsible party Date