

FINANCIAL ARRANGEMENT

Dr. Neil Millikin
3720- C Gosford Rd. Bakersfield, CA 93309- 3518 Wagon Wheel Rd.
Lake Isabella, CA 93240
661-831-9024

For Professional Services Rendered or to be Rendered:

Patient _____

Service _____

- 1. Estimated Professional Fees \$ _____
- 2. Estimated Insurance Payment \$ _____
- 3. Estimated Balance Due \$ _____

(Estimates valid for 60 days)

I understand that due to insurance policy changes and/or necessary changes in treatment plans, the insurance coverage may vary from this estimated treatment calculation. I acknowledge that this is an estimate only and understand that I, not the insurance company, am ultimately responsible for the payment in full for all services rendered.

I understand that all services are due to be paid in full within sixty (60) days of the date of service, whether or not my insurance benefits have been received. Should my account exceed sixty days...one and one-half (1.5%) interest per month (18% per year) will be charged. **There are no guarantees of insurance benefits.**

Responsible Party	Date	Financial Coordinator	Date
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