Schedule and Payment Agreement

- Insurance claims will be submitted by Dr. Manning's office as a courtesy to me the patient. Each patient, and not their insurance company, is responsible for the payment of all charges for the day of treatment.
- Please remember that certain services are not always covered by every insurance company. It is your responsibility to know whether your insurance plan will cover the services you choose. It is simply not possible for our staff to know the details of each and every insurance plan. We do our best to estimate insurance benefits.
- I give permission for Dr. Manning's office to charge my card, should my account fall 60 days past due.
- A $25.00 charge will be applied to my account for any returned checks.
- We understand how valuable your time is and ask the same of you. When you schedule an appointment, we reserve that time especially for you. We ask for 48 hours notice should you need to change your appointment for any reason. A $50.00 fee will be incurred without proper notice.
- By signing below, I agree to the above terms and I agree to pay any collection costs, if a delinquent balance is placed with a collection agency for any collection suit.

Preference of Payment: ___________________________Exp. _________CRV# ________ Visa, Master Card, American Express, Discover

Name (Print):_______________________________________Date:___________________

Signature____