Financial Obligation Agreement

Client's Name: ___________________________ Client's ID#: _______________ DOB: ___________

I agree that I am responsible for all fees associated with the rendering of professional services to my child and/or family by Wellmore.

If insurance coverage is applicable to these services, I understand Wellmore will bill the appropriate insurance carrier for any charges incurred. I will be responsible for what is determined to be my portion at the time of the visit and what is not paid by the insurance company after the claim is processed.

I will immediately provide Wellmore with all information that is required to determine insurance benefits.

I agree to notify Wellmore immediately of any additions, cancellations or changes to the insurance coverage associated with my child and/or family.

I agree to pay the amount that Wellmore determines to be my balance based on the information that I have provided at the time of the visit.

I understand that if any applicable insurance payments are made to any other party than Wellmore, I am responsible for that portion also.

If no payments are made for any balance that are deemed to be my responsibility for 90 days, my account would be considered delinquent. I understand that services may be terminated due to nonpayment and that Wellmore may employ a collection agency to collect this balance.

Client Signature: ___________________________________ Date: ___________________

Guardian's Signature: _______________________________ Date: ___________________

Guardian's Printed Name: ____________________________

Witness:____