NEBRASKA
MYOFUNCTIONAL SPECIALTIES

Acknowledgement of Financial Responsibility

Please initial each individual statement, signifying you understand each statement, and sign where indicated.

_____I understand that Nebraska Myofunctional Specialties, LLC and Patricia Brinkman-Falter are not preferred providers or in-network therapists for any dental or medical insurance companies.

_____I understand that although they are not preferred providers or in-network therapists for any dental or medical insurance companies, Nebraska Myofunctional Specialties, LLC will provide superbills and a GAP exception letter so I may realize any out of network medical benefits from my insurance policy.

_____I understand that the fee for my consultation appointment is due the day of the consultation appointment.

_____I understand that the Nebraska Myofunctional Specialties, LLC does not accept assignment from the insurance companies and if the insurance payment is assigned to Nebraska Myofunctional Specialties, LLC it will be reimbursed to me or credited to my account.

_____I understand that any subsequent treatment I agree to with Patricia Brinkman-Falter of Nebraska Myofunctional Specialties, LLC will require a signed treatment plan.

_____I understand that Nebraska Myofunctional Specialties, LLC offers a limited variety of payment plans for treatment.

_____ I understand that my appointment time has been reserved especially for me and if I miss my appointment or cancel with *less than 24-hours' notice*, I will be charged a fee of $40.00 on the second violation and thereafter.

_____I understand that if I arrive late (>15 minutes) that I will be offered the next available appointment. In these cases, a no-show charge for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment *may or may not be* on the day the appointment was missed.

_____ I understand that there will be a 1% compounded interest charge each month on any unpaid balances.

By my initials above and signature below, I acknowledge understanding of my financial responsibility for seeking treatment at Nebraska Myofunctional Specialties, LLC.

_____ _____

Signature Date

_____

Printed name of Patient