

**Kingstowne Internal Medicine Policies**

I have read and fully understand the fee policies (No Show, Late cancellations, Payment policy, Forms/Letters, paper prescriptions), and procedures (Emails, Reminder calls) of Kingstowne Internal Medicine and agree to these terms.

I understand that I am solely responsible for the balance due on my account. I agree to pay the unpaid balance due. If your account balance matures to over 120 days and remains unpaid, you will be sent a collection notice and your account will be sent to our attorney. Fees, court cost and interest of 1% a month will be assessed to your account. All of which you the payer will be responsible. We hope that this is not necessary; however, we are legally required to notify you of this.

We appreciate your patronage and if you have any questions or concerns, please ask.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsibility Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

\*\*A copy of the policies are available upon request.\*\*\*