FINANCIAL POLICY AGREEMENT

Thank you for selecting The Men's Clinic - Madison for your health care needs. We are pleased to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered. For your convenience, we accept Visa, MasterCard, and checks.

By signing this Financial Policy Agreement, I agree that should this account be referred to an agency or an attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs.

I acknowledge that I may or may not be medically eligible as a result of my lab tests. I have read and understand all of the above and have agreed to these statements.

Printed Name:____

Signature:____**Date:**____________

Phone Number:____

E-mail Address:____

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