

Robert O. Zimmerman M.D.
Financial Policy

Thank you for selecting Dr. Zimmerman for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept Visa, MasterCard and checks.

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

Signed _____ Date.



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