### FINANCIAL POLICY

### PATIENT AUTHORIZATION AND PAYMENT OF MEDICAL BILLS

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Center for Physical Therapy and Sports Medicine, PC, to apply for benefits on my behalf for covered services rendered. I request payment from Medicare, and or an insurance company, be made directly to the above-named provider (or in case or Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or the above named carrier at any time in writing.

Our policy is payment is to be made at the time of services rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance company. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above. If payment is issued to me, I will be responsible for payment of all my charges within 30 days. Should this account be turned over to collections, I understand that I will be responsible for 33 1/3% attorney fees, court costs and interest on the unpaid balance of 18% per year. For any returned check there will be a $25 service charge.

* PATIENT AGREEMENT

I understand that it is my responsibility to comply with the outlined prescribed treatment in order for my treatment goals and objectives to be met. I understand that I may not miss any scheduled appointments without prior notification to the Center for Physical Therapy and Sports Medicine, PC. If I am unable to arrive for my appointment at my scheduled time, I understand that I must give the office two (2) hours’ notice or I will be charged a $45.00 fee, and my attorney or worker’s compensation case manager will be notified, if applicable.

I understand that the Center for Physical Therapy and Sports Medicine, PC has accepted me as a patient, and I understand and accept the importance of following the treatment plan and objectives of my program.

I also acknowledge that I received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Date Signature of Subscriber or Beneficiary