

FINANCIAL AGREEMENT

The undersigned agrees to direct payment to the clinic of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services rendered. In the event that your insurance plan or carrier does not reimburse the clinic for charges and associated expenses incurred by the patient or if the benefits under such insurance plans cease while the patient continues outpatient therapy the undersigned agrees to pay all charges and associated expenses not covered by those insurance plans for whatever period the patient continues outpatient treatment at the clinic. I understand that I am responsible for any and all amounts due that are not paid by my insurance company for any reason, along with any and all collection and legal fees incurred by this office in order to ensure payment on my account in full in a timely manner. I also hereby authorize Atlantic Physical Therapy and Rehab and all of its employees to furnish any necessary information to my insurance carriers and legal council concerning my treatment, and I hereby assign all payment for medical services rendered to me or my dependents to the Clinic, Physical Therapist & Occupational Therapist. Payment plans can be arranged at the Clinic Business Office if deemed necessary. If your insurance plan changes or ceases during the course of treatment; it is **your responsibility** to notify the Business Office **immediately**.

I authorize the release of any medical information necessary to process insurance claims. **Payment is to be made directly to the clinic for services provided.** I understand I am responsible for any amount not covered by the insurance. I understand any bill unpaid after 30 days is outstanding and will be charged a rate of 1.5% per month and 18% per annually. Auto and Worker's Compensation have additional billing/financial agreements- (see form for Auto and Worker's Compensation).

GUARANTEE OF PAYMENT

If the undersigned fail(s) to make any payments due hereunder, clinic may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise(s) to pay all cost of collection, including, but not limited to, attorneys fees equal to fifteen percent (15%) of any amount due and owing to the clinic, and any other collection fees which are incurred by or on behalf of the clinic in enforcing payment after default. The undersigned expressly agree(s) and stipulate(s) that if, in the sole discretion of the clinic, its representatives or its attorneys, litigation or court process is necessary to enforce payment hereunder, that the venue for any such litigation or court process shall be the Circuit Court for Worcester County, Maryland, or the District Court of Maryland for Worcester County, Maryland, and the undersigned hereby expressly waive(s) any right of venue or trial in any county or jurisdiction other than Worcester County, Maryland.

MEDICARE AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf I assign the benefits payable for services to the physician or Organization furnishing the services or authorize such physician or organization to submit claims on my behalf.

PATIENT RIGHTS AND RESPONSIBILITIES

A patient shall be fully informed of their rights and responsibilities and of all procedures governing patient conduct and responsibilities. The information will be provided to a patient by written via a copy at the time of admission. The undersigned acknowledges receipt of this information. When a patient is mentally retarded or incapacitated; the signing must be signed by a caretaker, legal guardian or witnessed by third party.

The undersigned certifies that he/she has read the above and fully completed all requested information. The undersigned has received copies thereof, and is the patient or is duly authorized by the patient as the patient's legal guardian/representative.

Signature: _____ DATE: _____

**** Privacy Policy Copy attached ****

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

*You may refuse to sign this acknowledgment. You are entitled to a copy of this consent after you sign it. *

Atlantic Physical Therapy & Rehabilitation will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operation. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Notice of Privacy Practices to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice.

I, (printed name) _____, have received a copy of this facility's Notice of Privacy Practices.

Signature: _____ DATE: _____