VANITA'S REHAB

31 NELSON AVENUE,
MELBOURNE, FL 32935
Phone: 321-432 5573 Fax: 321-726 9938

OFFICE FINANCIAL AND INSURANCE POLICY

Payment Agreement: I understand that I am responsible for all charges for treatment received regardless of insurance coverage. I understand that my portion of the visit is due as payment at the time the services are rendered.

I understand that my insurance agreement is strictly between my insurance carrier and me. I further understand that the Provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim.

I understand that it is my responsibility to provide the Provider with accurate and current insurance information.

I understand that my benefits can only be *estimated* based on the most current information provided by my insurance carrier. I understand that my insurance plan has a maximum benefit, which can be tracked to some extent. However, if I have recently received care from another provider, this office cannot be expected to accurately calculate my remaining benefits.

Any remaining balance once my insurance pays the Provider becomes my sole responsibility. I agree to pay this balance immediately upon receiving notification of the same. I further understand that if my insurance company fails to pay within 60 days, or denies the claim for any reason, I will become responsible for the full amount due.

I understand that this office does not accept secondary insurances as a form of payment, but that a claim will be submitted on my behalf and the check may be sent to me directly for reimbursement. I hereby undertake to immediately endorse and mail this check to this office or send my personal check for the amount sent to me by the secondary insurance along with a copy of the letter from insurance explaining the payment. I also understand that the Provider is not responsible to track payments from secondary insurances.

The provider reserves the right to decline further services to the patient for non-payment.

I agree to pay the finance charges levied by bank on any returned checks and 18% APR applied to all outstanding balances over 60 days.

I understand and agree that if my account is placed into collection action, I will be responsible for all the costs resulting from such action (including collection agency and/or attorney fees).

I assign benefits payable for services to the therapist furnishing the services and authorize the therapist to submit a claim to my insurance carrier on my behalf.

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**