FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: ____/_____/_____

I give consent to Element Physical Therapy (EPT) for the provision of physical evaluation and treatment, whether self- referred or by administered physician orders.
I hereby authorize EPT to furnish information to the parties deemed necessary for the purpose of treating my illness/injury and for claims processing.
I agree to assign to EPT all insurance and third-party payments for services rendered and I understand that I am financially responsible for all charges not covered by insurance or third party liability.

A charge of $30.00 service fee for any returned checks.

Co Payments are expected to be paid before service is rendered:

- I understand that co payments are expected to be paid before service is rendered and service will be denied if co payments are not made prior to service.
  - _____ **(please initial)**

Please make every effort to keep your scheduled appointments:

- I understand that appointments missed or cancelled without 24 hour notice may be subject to a $30.00 fee, at the discretion of EPT, as missed appointments are not covered by insurance.
  - _____ **(please initial)**

Statements will be sent for balances due and an interest charge will be added to balances older than 30 days:

- I understand that statements will be sent for balances due and payment is expected within 30 days from the date of the statement regardless of an attorney being obtained for settlement purposes.
  - _____ **(please initial)**

- I understand that a charge of $5.00 will be added monthly to balances due that are older than 30 days, until the delinquent balance is paid in full.
  - _____ **(please initial)**

If my account is turned over to a collection agency I will be responsible for:

- Any and all third party fees including attorney fees and reasonable agency fees.
- Collection fees in the amount of up to 50% of my total account balance will be added to the remaining balance.
  - _____ **(please initial)**

I agree to the terms specified above.

Patient signature: _____ Date: ____/____/_____

If patient is under the age of 18 years old:
I give permission to treat the above said minor in my absence.

Signature of Responsible Party: _____ Date: ____/____/_____
Relationship to Patient: _____