Acknowledgment of Administrative, Clinical & Financial Policies:

FYZICAL Health is dedicated to providing you with the best possible care and service while keeping the charges at a reasonable level. As a patient in our practice, it is important that you are aware of our policies. We ask that you read this in its entirety and have any questions answered by our staff.

Insurance: We participate in most medical insurances. It is important to understand that insurance is an agreement between you and your physician. If we do participate with your insurance, all services will be submitted to your carrier for deductibles at the time of the visit and the full fee for non-covered services.

Some insurance plans, including HMO's may require an authorization from your referring physician for medical services. It is your responsibility to obtain the authorization to the time of service. If the required authorization is not presented at the time of service, you may do one of the following:

1. Reschedule the appointment and obtain the authorization prior
2. Contact the referring physician to authorize the visit
3. Pay the charge for your services and seek insurance payment

If we do not participate with your insurance, payment is required at the time of service. We accept Visa and MasterCard credit cards, as well as, cash or check. Your account is not satisfied until your check clears the bank. Should your check be returned, you will be liable for any bank fees levied and an additional fee of $20 for administration. Some procedures performed by us are considered "cosmetic" in nature and are not covered by the insurance carriers. Full payment for cosmetic services is required prior to the surgery.

Cancellations: Please provide 24 hours' notice if you must cancel or reschedule your appointment, otherwise a $50 cancellation fee may be assessed.

Collections: If your account becomes delinquent, your account will be sent to a collection agency. In that event you will be financially responsible for all collection fees incurred, unless contractually prohibited. This means you will owe both the original balance and any fees incurred by using the collection agency to secure payment. Payment for current services and payment in full of any past due balance is expected prior to the surgery. If there is a credit balance, we will refund the amount by check after all visits are completed. The expectation is that we will not refund amounts less than $5.00.

Medical Records and Forms: If you require a copy of your medical records, a fee may be charged to offset our costs. All fees are payable prior to the release of records. Government regulation limits, but allows for these fees and requires us to obtain a Medical Records Release authorization for prior to release of your records. If you require FMLA, disability or other forms to be completed, a fee of $25 will be charged.

Photography Release: I understand that photographs may be taken in connection with the medical services I receive and that such photographs will be retained in any medical record that may be shared with others, including, but not limited to, my insurance carrier. I give permission for these photographs and information relative to them and/or relating to my case to be published and republished for the purpose of medical research, education or science; I specify that such publication of the photographs will not include my name. I understand that this release is valid unless I revoke myself.

Medicare& Medical Insurance Signature on File: I may have provided an insurance information document that may provide payment for services. I authorize payment of medical benefits directly to the physician for services rendered. I am financially responsible for all charges for services rendered to me, including the balance remaining after the payment of any insurance benefits.

Permission to Treat: I hereby give the physician and those under the supervision of the physician, permission to treat me as a patient. I will comply with their recommendations for treatment, tests and/or referrals to other specialists as may be necessary for my care.

Notice of Privacy Policy Acknowledgment: I hereby acknowledge that I have seen/ reviewed the "Notice of Privacy Policy" displayed in the waiting room and that I may have a paper copy should I so desire.

Financial Agreement: I understand that I am directly responsible for my account, the payment of this account and hereby assume and guarantee payment of expenses incurred by myself and/or my dependents. Should legal action be required to secure payment of this account I agree to pay reasonable collection expenses, all court costs and a reasonable attorney's fee incurred thereby.

Other Person's we may speak to regarding your health information, such as appointments, test results, etc:

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_____ _____ ___/___/___

Guarantees Printed Name Signature Today's Date