

FINANCIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. I have reviewed the Office's Assignment from titled in short "Assignment" or "Assignment/Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Terms of My Coverage. I understand that in any given situation, a Payer may refuse to pay for a particular Charge incurred at the Office, or may actually request a refund from the Office after making payment. I understand, for instance, that a Payer may deny payment for a Charge, stating that the Charge is "not covered" under its policy or exceeds some other limitation. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary, either in whole or in part, and should therefore be denied, downcoded, or bundled with another code. Unless otherwise agreed to in writing, I agree that I am solely and exclusively responsible for verifying all exclusions and limitations in the policy of any Payer. I also agree that I am solely and exclusively responsible for verifying all exclusions criteria used by any Payer to assess the medical necessity of my Charges. Should any Payer deny payment, or request a refund, based on an exclusion or limitation in the policy, or should any Payer deny payment or request a refund based on the rationale that a Charge was not medically necessary, consistent with the previous provision, I agree that I am personally and fully responsible for the denied portion of my Charges, minus any applicable fee schedule discounts.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature _____ Date: ____ / ____ / ____

Name of Custodial Parent of Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date ____ / ____ / ____