Financial Agreement:

The patient will be responsible for **all copay, deductible** a**nd coinsurance amounts due at the time services are rendered.** Our office accepts cash, checks and Visa/MasterCard/Discover/American Express credit and debit cards.

I understand that this office will **make every attempt** to obtain payment from my insurance carrier including Medicare and/or other third party payer. I acknowledge and understand that payment for services may be denied by my insurance carrier, including, but not limited to, pre-existing conditions, routine, experimental, not reasonable or necessary, or work **related reasons.**

IF MY INSURANCE PAYS ME DIRECTLY, I agree to forward the payment to this office within 10 days of my receipt of **payment**. I further understand that failure to comply with this policy could result in Milestone Physical Therapy and Training LLC taking appropriate legal action to collect this amount. I acknowledge that I am financially responsible for all fees incurred for services rendered regardless of insurance.

Any balance on my account that remains unpaid for more than 60 d**ays may be assesse**d a rebilling fee of $25.00. If a balance remains unpaid for more than 90 days, the account may incur an additional $50.00 rebilling fee. Once a balance goes unpaid past 100 days, the account may be turned over to a Third Party Collections Service.
You agree that you will pay any interest that can be added at the current legal rate as well as all collection fees, returned **check fees, attorney fees a**nd court costs incurred for the collection of all sums due. Payment plans are available up to but not exceeding 6 months. Any missed payments will be subject to a 5% interest charge per month as well as the late fees indicated above.

Additional Fees: *A* fee of $50.00 cancellation fee will be charged if cancellation is less than 24 hours. *A* fee of $25.00 will be charged for any returned check. A one-time fee of $18.00 will be charged if dry needling is indicated for your plan of care. This fee is not covered by insurance. Any supply or durable medical equipment provided to you will exclusively be your financial responsibility and will need to be paid for at the time of purchase. Assignment of Benefits I authorize and direct my insurance carrier to pay benefits to Milestone Physical Therapy and Training, LLC for **services rendered to me, regardless of the** carrier's policy concerning this office. This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be **considered as effective** and valid as the original. My signatur**e affixed here may** be kept on file to suffice for any signatures required on insurance claim forms. In addition, I authorize Milestone Physical Therapy and Training, LLC to release pertinent information to my insurance carrier(s) and the Indiana Department of Insurance concerning my condition and **treatments rendered.** I have read this financial policy. I understand and agree to comply with this financial policy. I authorize the release of any medical information required throughout the course of **examin**ation and treatment and permit payment directly to Milestone Physical Therapy and Training LLC for any monies due for the services **rendered.**

Patient Name (Printed): ____

Signature of Responsible Patient:____**Date:**__________________________

Signature of Milestone Physical Therapy & Training Representative:_________________________________**Date:**______