

*Dynamic Rehab Inc.*

FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

- 1) As a service to you, this office will bill your insurance company. We ask all insurance companies pay us directly.
- 2) I authorize \_\_\_\_\_ insurance company to make payment directly to Dynamic Rehab Inc. directly.
- 3) I understand that as the patient or guardian I am responsible for all charges whether or not paid by insurance.
- 4) Payment is expected within 30 days after the first statement is sent and is consider past due if a second statement is sent. Balance older than 60 days are subjected to additional collection fees and interest charges of 1.5% per month.
- 5) It is important that your appointment be kept. We ask that at least 24 hours' notice be given if you can't keep your appointment. There is a \$25 service charge for an appointment missed without notice.
- 6) If a patient is a minor, a parent or guardian must be present at the first visit to sign treatment authorization and payment agreement forms before the patient can be seen.

I HAVE READ THE ABOVE PAYMENT POLICIES AND AGREE TO THE TERMS OF THESE POLICIES. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO ENFORCE PAYMENT OF ANY CHARGES, I AGREE TO BE RESPONSIBLE FOR AND PAY ALL ATTORNEY'S FEES AND COURT COSTS INCURRED.

CONSENT TO TREAT

I authorize Dynamic Rehab to provide physical therapy services to myself or my dependent. I further authorize Dynamic Rehab Inc. to release any information in the course of my examination or treatment to my physician, insurance company, lawyer, or other health professionals.

SIGNED \_\_\_\_\_  
PATIENT OR GUARDIAN

DATE \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_