PAYMENT, CONSENT AND POLICY FORM

_____**PRIMARY INSURANCE**: As a courtesy, we will bill your primary insurance. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding after 60 days will be due in full from you regardless of insurance type. Any remaining balance after your co-pay and primary coverage have been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier.

_____**MEDICARE**: We will bill Medicare for you. In most cases Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

_____**SELF PAY**: Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised we are not a credit grantor, and failure to maintain these arrangements may result in the placement of your account with a third party for collection.

_____**WORKERS' COMP:** We will bill your workers' comp carrier for you. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

_____**LEGAL SUIT**: We will accept a legal letter of protection if you meet each of the following criteria:

1. Do not qualify for benefits under any insurance policy (medical or auto), and
2. Are indigent and cannot pay for charges due using cash or credit card, and
3. Are awaiting settlement and subsequent payment of damages from a related legal case, and
4. Return our signed *Patient Agreement to Assign Health Care Benefits to Provider* form.

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of last treatment. Upon settlement of your legal case, your balance in full is due within 30 days.

_____**CANCELLATION POLICY:** A charge of $50.00 is billed directly to the patient for each instance a patient fails to show for a scheduled appointment or does not give at least **24 business hour** cancellation notice. Please note this is not payable by any insurance company. Patients will be discharged after 3 no shows or late cancellations.

_____**CONSENT TO TREATMENT:** Signature of this form constitutes consent to rehabilitation and related services at Horizons Therapy. The patient understands, acknowledges and affirms such rehabilitation and related services may involve bodily contact.

_____**TREATMENT OF MINORS:** By signing below, parents/guardians of minors receiving treatment agree and understand they are advised to remain on the premises during treatment, and waive any claim resulting from failure to do so.

_____**LIABILITY:** Horizons Therapy is not responsible for loss or damage to personal valuables.

_____**WAIVER AND RELEASE:** Horizons Therapy Inc, its agents, representatives, affiliates, employees, or assigns, are released, discharged and acquitted of and from all liability, claim, demand, cause of action, or loss of any kind arising out of resulting from my refusal to accept, receive or allow emergency and or medical services.

_____**PRIVACY POLICY**: Signing below indicates the Horizons Therapy's HIPAA policy and procedures have been explained and a copy of the policy has been provided to the patient.

_____**CoPays:** CoPays are due in full on date of service unless other arrangements are made in advance.

I hereby assign all medical benefits to which I am entitled to Horizons Therapy, Inc. In the event they file insurance on my behalf, **I understand that I am financially responsible for all charges whether or not paid by said insurance**. In the event my account becomes delinquent (after 60 days) and is there in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to liquidated damages calculated as 25% of the current principal balance, collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 18% annually for unpaid balances over 60 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I understand that a $30.00 charge for returned check fees will apply. I do hereby consent to such treatment by the authorized personnel of Horizons Therapy, Inc as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

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AUTHORIZED SIGNATURE (Seal) DATE