FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth:_____

IF APPLICABLE

Guarantor's Name:_____Guarantor's Date of Birth:_____

DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to AGM Physical Therapy for services rendered to me or my dependents. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that AGM Physical Therapy is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID INSURNACE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependents, records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to AGM Physical Therapy on my behalf.

FINANCIAL RESPONSIBILITY AGREEMENT:

As a courtesy AGM Physical Therapy will make every reasonable attempt to call my insurance to inquire about my outpatient physical therapy benefits. AGM Physical Therapy is not responsible for information obtained from the insurance company that is incorrect or missing information. ***AGM Physical Therapy advises me to contact my insurance company to obtain my benefit details.***

I understand and agree it is my responsibility to recognize the therapist is contracted with my insurance and I have verified the therapist is an 'In Network Provider' through my insurance. If the therapist is not contracted and is considered an 'Out of Network Provider', my insurance benefits may be reduced or denied and I will become financially responsible for any unpaid amounts.

Many insurance companies have additional stipulations that may affect my coverage. I understand I am responsible for all fees regardless of insurance coverage.

My health insurance policy is a contract between me and my Health Insurance Company or employer. It is my responsibility to know if my insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient visits. AGM Physical Therapy is not a party to that contract and is not required to act as a mediator with the carrier or employer. I agree to assume responsibility for any amount not covered by my insurance.

I understand and agree that AGM Physical Therapy, or their authorized agents, will be able to contact me electronically and via phone in order to collect balances accrued from services.

All balances must be paid within 30 days from the date of invoice. If AGM Physical Therapy must pursue legal action against me to collect any amounts owed by me to AGM Physical Therapy, I agree to pay AGM Physical Therapy's expenses, including reasonable attorneys' fees, incurred as a result of legal action.

_____ _____

Patient / Guardian Signature Date