

NAME _____

PLEASE READ AND SIGN

I, _____, agree to pay \$_____ each treatment OR

I, _____, agree to pay \$_____ weekly.

NO INTEREST OPTION: (Same as Cash) Account must be paid in full within 45 days. No interest period ends on _____, 20____. Account Balance:\$_____.

Interest Rate: Interest will be added to all accounts that are not paid in full within the first 90 days of the first billing. A charge of 18% per annum will be charged on the unpaid balance.

Late Charge Fee: If you fail to pay the monthly scheduled payment in full by the due date on this Pay Agreement, you agree to pay a late charge of 5% of the monthly payment or \$5.00, which ever is greater.

Return Check Fee: If any check or other instrument for payment on your account is dishonored for any reason, you agree to pay a Returned Check Fee of \$25.00. If suit is filed, we reserve the right to sue for triple the amount of the check up to \$500.00 with a minimum of \$100.00.

Change of Name, Address, or Employment: You agree to give us prompt notice of any change in your name, mailing address, or place of employment.

AUTHORIZATION TO TREAT AND RELEASE INFORMATION: I hereby authorize Therapy Services Associates (TSA) to treat the patient indicated on the other side of this page. The undersigned authorizes Therapy Services Associates, P.C. to release medical or other information about the patient, which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payers, including the third-party payer's agent and/or representative.

ASSIGNMENT OF BENEFITS: The undersigned authorizes payment of benefits, including insurance benefits, otherwise payable with respect to the patient, to Therapy Services Associates, P.C.. The undersigned agrees to assist in the processing of claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Therapy Services Associates, P.C. during my treatment.

FINANCIAL RESPONSIBILITY: The undersigned jointly and severally agree to pay for all treatments administered by Therapy Services Associates, P.C. It is understood and agreed charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable attorney fees, open account interest charges assessed, late charge fees, and returned check fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, jointly and severally, agree to pay all charges not paid in full by a third-party payer. If I have insurance, I understand that my insurance company has entered into a contract with me and not with Therapy Services Associates, P.C. and I am responsible for payment for all services rendered to me.

Your signature means that you have read and agree to the terms of this Pay Agreement and authorize Therapy Services Associates, P.C. to perform a credit check if deemed necessary.

_____/_____/_____
SIGNATURE DATE WITNESS