FINANCIAL AGREEMENT
CHCC OUTPATIENT THERAPY

Patient Name: ________________________________ **Date: ____________________**

I do hereby agree to pay Christian Health Care Center (CHCC) the full and entire amount of any and all costs for therapy or services related to my care.

I understand that CHCC cannot guarantee that my insurance coverage will be adequate to pay for all services rendered. I also understand that I am responsible for complying with my insurer's requirements regarding my coverage. If my insurer denies coverage, I agree to be responsible to CHCC for payment of all bills related to my care. I will be responsible to pay the balance of any bills not paid by insurance in accordance with CHCC's standard billing terms, which require payment in full of all charges billed by the 20th day of the month following the month in which bills occurred. I agree to make payments of co-pay, deductible or set fees at time of **each** visit.

I understand that if I cancel an appointment less than 24 hours or do not show for an appointment, I may be charged for that appointment, which is not covered by insurance.

I understand that failure to make payment in accordance with this agreement will result in the assessment of finance charges at the rates of 1 ½ % per month on unpaid balances, which I will be responsible to pay. Should it be necessary for CHCC to engage an attorney or collection agency for the purpose of collecting such unpaid balances, I agree to pay for any and all related costs and fees. This consent will expire at the time that I no longer have any unpaid balances to CHCC.

I hereby authorize CHCC to release any medical information acquired in the course of my therapy which may be needed to process a claim for insurance benefits. Any violation of the terms of this contract shall be just cause for the termination of CHCC's obligation to provide further services to me. Based upon such violations, I may be referred to another provider.

Assignment of Benefit: I hereby authorize payment directly to CHCC of the insurance benefits otherwise payable to me, but not to exceed the balance due of CHCC's regular charges for these services. I agree to remit to CHCC any payment directly to me for these services to be applied to my outstand balance until paid in full.

Guarantee of Payment: In order for CHCC to enter into a Financial and Service Agreement (the "agreement") with ___________________________ (the "patient") the undersigned ("patient") hereby guarantees compliance with regulations dictated by the insurance carrier, including but not limited to the payment of copayments, deductibles, and non-covered charges. If the patient fails to notify CHCC of a change in insurance coverage, the patient will be held responsible for the resulting balance due. This agreement is unlimited, continuing, and absolute with respect to each of the terms and conditions and obligations of the client under that agreement. The patient agrees that the institution may proceed to bill and/or collect pay for services rendered. I have read and understand the Financial and Service Agreement.

REFUSAL TO SIGN THIS FORM WILL RENDER THE CLIENT RESPONSIBLE FOR PAYMENT

Signature: _______________________________ Print Name: ______________________________

Relationship to patient (if not patient): __________________________________ Date: ________

If signature is provided by legal representative, please attach documentation of legal status.