Patient Payment Agreement

Meadowland Therapy, Inc
1033 W Quinn Rd, Pocatello, Id 83202

Please note: The Benefit Plan/Insurance Contract is between you (the patient) and the Benefit Plan issuer or the Insurance Carrier. As a courtesy to our patients we will bill insurance when we are given the necessary information. It is your responsibility to know what your insurance will pay, and to know if prior-authorization is required, for Physical and Occupational Therapy services with our staff.

Please initial:

____ **Appointment Policy:** My appointment is time that has been reserved especially by me, for me. If I must change my appointment I will give at least 24 hours notice. I understand that if I do not give proper notice my account may be billed a $50.00 cancellation fee. We appreciate your consideration of our time and that of all our patients.

____ **Financial Agreement:** All charges incurred with Meadowland Therapy, Inc. (the clinic) are my responsibility, and payments for such services are due at the time services are rendered unless otherwise approved in writing by the clinic. Monthly payments are required to keep my account in good standing. Any unpaid balances may be forwarded to a third party for collection 120 days after initial billing. Should the account be referred for assignment, I will be responsible for payment of all costs and collection expenses, including a 30% collection fee, accrued interest and attorney fees. For my convenience, I may place a credit card on file and arrange monthly payments towards my balance to be made automatically by the clinic.

____ **Assignment of Benefits:** I authorize the clinic to bill my insurance company directly. I understand that I remain financially responsible for all charges not covered by insurance. These charges may include, but are not limited to, deductibles, co-insurances, co-pays, and non-covered services. **Co-pays are due at the time of service.** I hereby assign and transfer all of my rights, title and interest in any insurance policies of which I am the insured, to the extent of the amounts I owe the clinic, subject to all of the terms, provisions and conditions contained in said insurance policies. I further authorize payment of medical benefits to be made directly to the clinic by my insurance company.

____ **Assignment of Other Interests:** I hereby assign to the clinic all of my rights, title, and interest in and to every other contract or agreement under which I am owed sums by any individuals, or entities, resulting from my injury or condition, to secure payment of any sums I owe the clinic for services rendered hereunder. I will inform the clinic if my condition is the result of an auto accident, work injury, and/or any other injury in litigation.

____ **Release of Information:** I hereby authorize the release of any and all information necessary to process my insurance claims and/or to obtain payment, by the clinic on amounts I owe for services rendered or product/therapy supplies purchased.

____ **Notice of Privacy Practices:** I have been offered a copy of the company's privacy practices and I am aware that a copy is available to me, and I can request a copy at any time.

____ **Binding Effect:** This agreement shall be binding upon my executors, liens, and assigns.

____ ____________________
Signature of Patient, Authorized Representative, or Responsible Party — Date

____ ____________________
Print Name of Patient, Authorized Representative, or Responsible Party — Relationship to Patient