FINANCIAL AGREEMENT

1. **RELEASE OF INFORMATION FOR REIMBURSEMENT:** To the extent necessary to obtain reimbursement, the Facility may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the Facility's charges, including but not limited to, insurance companies, healthcare service plans, workers' compensation carriers, social security administration and peer review organizations. You agree that, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. The undersigned have read this disclosure and agree that the Lender/Creditor and its agents may contact me/us and describe above.
2. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account of the Facility in accordance with the regular rates and terms of the Facility. She the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
3. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the Facility of any insurance benefits otherwise payable to the undersigned for services rendered at a rate not to exceed the Facility's usual and customary charges. It is agreed that payment to the Facility, pursuant to this authorization, by an insurance company/Health Care Service Plan shall discharge said insurance company/Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the understanding that he/she is financially responsible for charges not covered by this assignment, or for not cooperating with requests for information by the insurance company/Health Care Service Plan.
4. **HEALTH CARE SERVICE PLAN:** The Facility has contracted with multiple Health Care Service Plans. It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services at the Facility. It is also the responsibility of the undersigned to verify if the Facility is within their covered Network.

   The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible, co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health Care Service Plan at the Facility. For non-emergency services, it is the patient's responsibility to ensure his/her Plan has authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergent services will be considered a denial for a non0covered benefit, and payable by the undersigned.

The undersigned acknowledges he/she has read and understands the Financial Agreement, Assignment of Insurance Benefits, Health Care Service Plan obligation and all other applicable provisions above, and is the patient, the patient's legal representative or duly authorized as the patient's general agent to execute the above and accept its terms.

_____	_____	_____
SIGNATURE:PATIENT/LEGAL REPRESENTATIVE	**DATE**	**RELATIONSHIP IF NOT PATIENT**