Financial Agreement

VASTA PHYSICAL THERAPY Inc.

Assignment of Benefits: I authorize direct remittance of payment from all insurance benefits or attorney(s) to VASTA Physical Therapy Inc. for all covered medical services and supplies provided to me during all courses of therapy and care provided to me by VASTA Physical Therapy Inc. regardless of its managed care network participation status. I also understand that I may revoke this assignment at any time by sending written notice to the Provider and my health plan. l hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor.
I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for any charges not covered by health care benefits, regardless of the outcome of my suit or negotiations as presented by VASTA Physical Therapy Inc. It is my responsibility to notify the office staff of any changes in my health care coverage.
In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the clinic or my health care insurer if the submitted claims or any part of them are denied for payment or are paid directly to me. *I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.*

Policy: I am aware that it is the policy of VASTA Physical Therapy Inc. to collect *at time of service* all co-pays, deductibles, co-insurances and non-covered services.

I am aware of VASTA's no-show/late cancellation policy.

I have had the opportunity to read through VASTA's "Extended Policy Statement" regarding, but not limited to, Out-of-Network benefits, Medicare Policy, Pre-Paid Packages, Auto/Personal Injury Policies, Workers Compensation Policies, Appeals, Late-Payment and Collections Policies.

I am aware that if I make a payment by check that has insufficient funds, I will be charged a 'returned check' fee of $35.

Name: ______________________________ Date: __________

Signature: ______________________________

Signing for (if applicable): ______________________________
* write name of patient if signing as guarantor