



FINANCIAL AGREEMENT

It is to my understanding that The Functional Performance Center is billing my medical insurance as a courtesy to me. **Any funds issued to me by my insurance company will immediately be paid to The Functional Performance Center.**

_____ **initial**

I understand that this account is my financial responsibility and if I or my insurance company does not comply with the above agreement, my therapy will be discontinued and payment on my balance will be due in full.

Also, I understand that I am responsible for the fee of **\$25 (per occurrence)** if I should miss a scheduled physical therapy appointment, unless I call and cancel at least 24 hours ahead of the scheduled appointment.

_____ **initial**

NOTE: Your deductible/co-pay/co-insurance will be collected at each visit unless otherwise stated. It would be in violation of FPC's agreement with the insurance company if your payment is not received at the time of service. If your account has an outstanding balance and we have made our attempts to collect that balance, we will forward your account balance onto our collection agency at which time you will be responsible for paying the collection fees (25% of your balance due) as well as your outstanding balance.

A \$20 Service Fee will be charged on all returned checks.

The information obtained from my insurance company by The Functional Performance Center is only a description of benefits - not a guarantee of payment. I am responsible for any fees not covered by my insurance company.

Patient/Legal Guardian Signature

Date