

## **FINANCIAL POLICY**

This is an agreement between Comprehensive Rehabilitation Group, Inc., as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours," mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Comprehensive Rehabilitation Group, Inc.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments/credits applied to your account during the month.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is received, and is past due if not paid by the end of the month.

**Co-pays:** Any co-payments required by your insurance company must be paid at the time service is rendered. Because this is an insurance requirement, we cannot bill you for these.

**Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a half (1.5%) percent per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent.

**Returned Checks:** There is a fee (currently \$30) for any checks returned by the bank.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs.

**Workers Compensation:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Auto Accident or any Litigation Policy:** In the event your injury was due to an auto accident or any other accident resulting in litigation our office will be happy to file your bills with your own auto med pay, your health insurance company or the responsible parties auto insurance company if they agree to pay at the time of service, otherwise payment is due by you on the date of service. Any deductibles, coinsurances or non paid

bills will be the responsibility of the patient. We do not accept attorney's letter of protection. **We will not wait for settlement on your claim for our services to be paid.**

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: \_\_\_\_\_

Responsible Party (if not the patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_