

2010 Physical Express Financial Agreement Form

ASSIGNMENT OF BENEFITS

I, the undersigned, understand that I am responsible for any amounts due Physical Express, LLC at the time of service. Physical Express agrees to file insurance for me; however, I remain responsible for any amounts not paid by my insurance company for services rendered. I authorize release of information necessary to process all insurance claims, and assign payment of all insurance benefits relating to my treatment rendered to Physical Express, LLC. I also consent to the use and disclosure of protected health information about me by Physical Express, LLC. for the purpose of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV). I certify that all information on my Patient Information Form is complete and correct.

AGREEMENT TO PAY

I, the undersigned, accept the fee(s) charged as legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33.33% collection fee, Attorney Fees, and/or Court Costs, if such becomes necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE

I, the undersigned, give Physical Express, its employees and/or agents “express prior consent” to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.

By signing below, I certify that I have read and understand all of the information contained herein. I further certify that I agree with the information as stated above and have had the opportunity to ask any questions with my questions having been answered to my complete satisfaction.

Print Name of Patient/Responsible Party

Signature of Patient/Responsible Party

Date