Financial Agreement Form

In order to obtain reimbursement for services provided to my child by Theracare Outpatient Therapy Services (TOTS), I authorize disclosure of my child's record for treatment, payment, and healthcare operations.

If the therapy services provider is a participating provider in my insurance plan, I hereby assign medical benefits due be paid directly to Theracare Outpatient Therapy Servces.

I understand that I am financially responsible for any balances not paid by my insurance carrier within 60 days from the date of services. If the patient fails to provide proof of insurance within 60 days, the patient is responsible for the balance in full. If no Secondary Insurance information is provided, I attest and affirm that I have no other insurance other than that listed as Primary Insurance. Patient with no insurance coverage are considered self pay patients.

I understand that if my child's account becomes delinquent it will be assigned to an attorney for collection and/or suit, and the prevailing party shall be entitled to reasonable attorney's fees and cost of collection and my family will be asked to seek medical care elsewhere.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Patient Name (Print)	Date
Signature	Date
Printed Name of Patient or Guardian (if under 18)	Date
Signature of Parent or Guardian (if under 18)	Date