FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: _____

IF APPLICABLE

Guarantor's Name: _____ Guarantor's Date of Birth: _____

DISCLOSURES & CONSENTS

ASSIGNMENTS OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Sisu Therapies for services rendered to me or my dependents. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Sisu Therapies is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependents, records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Sisu Therapies on my behalf.

DURABLE MEDICAL EQUIPMENT (DME), FUNCTIONAL DRY NEEDLING (FDN), AND OTHER SUPPLIES:

Insurance plans may/may not cover all/part/any of DME, FDN, and/or other supplies. Sisu Therapies staff, as a courtesy, will try to make you aware of these benefits. However, there may be charges that your insurance may not cover. Please be aware of your plan. Your clinician is making decisions based on providing you the best treatment and plan of care.

FINANCIAL RESPONSIBILITY AGREEMENT:

As a courtesy Sisu Therapies will make every reasonable attempt to contact my insurance to inquire about my outpatient physical therapy benefits. Sisu Therapies is not responsible for information obtained from the insurance company that is incorrect or missing information. ***Sisu Therapies advises me to contact my insurance company to obtain my benefit details.***

I understand and agree it is my responsibility to recognize the therapist is contracted with my insurance and I have verified the therapist is an 'In Network Provider' through my insurance. If the therapist is not contracted and is considered an 'Out of Network Provider', my insurance benefits may be reduced or denied, and I will become financially responsible for any unpaid amounts.

Many insurance companies have additional stipulations that may affect my coverage. I understand I am responsible for all fees regardless of insurance coverage.

My health insurance policy is a contract between me and my Health Insurance Company or employer. It is my responsibility to know if my insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, and limits on outpatient visits. Sisu Therapies is not a party to that contract and is not required to act as a mediator with the carrier or employer. I agree to assume responsibility for any amount not covered by my insurance.

I understand and agree that Sisu Therapies, or their authorized agents, will be able to contact me electronically and via phone in order to collect balances accrued from services.

All balances must be paid within 30 days from the date of invoice. If Sisu Therapies must pursue legal action against me to collect any amounts owed by me to Sisu Therapies, I agree to pay Sisu Therapies' expenses, including reasonable attorneys' fees, incurred as a result of legal action.

_____ _____

Patient / Guardian Signature Date