MADISON MEDICAL & SPORTS rehabilitation center

AN INTEGRATIVE MEDICAL SERVICES CO.

Last Name:	First Name:	DOB:

Financial Policy

I have been informed Madison Medical & Sports Rehabilitation Center is:

□ In-network with my insurance plan. I understand I am financially responsible for my copayment, deductible or coinsurance.

□ Out-of-networks with my insurance plan. I understand my potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan. I may be responsible for an excess amount above the allowed amount the health insurance plan pays.

I understand that within days of my care, service or treatment, a claim will be filed with my insurance carrier. If any funds are owed, payment is expected upon receipt of notification. If your insurance carrier sends payment for care, services, or treatment directly to myself (patient or guardian), I agree to forward payment to Madison Medical & Sports Rehabilitation Center. My insurance carrier may issue a check to me along with my explanation of benefits. I understand I may forward payment by either depositing the insurance-issued check into my personal account and sending a personal check in the amount due to the office or contact the office to provide a credit card payment. I understand I may also bring the check to the office and sign the check over to the office. I will provide a copy of my explanation of benefits with payment. Your signature below acknowledges you understand your responsibilities regarding financial payments.

Healthcare Providers

I understand that my Healthcare Provider bill separately from Madison Medical & Sports Rehabilitation Center.

I have been informed my Healthcare Provider is:

□ In-network with my insurance plan.

□ Out-of-networks with my insurance plan.

Laboratory Services

During care, service or treatment, my Healthcare Provider may order a blood or urine sample to be sent to a laboratory for analysis. These services are billed separately. Madison Medical & Sports Rehabilitation Center utilized the following laboratory:

I have been informed the laboratory is:

□ In-network with my insurance plan.

□ Out-of-networks with my insurance plan.

Assignment of Benefits

I, the undersigned, irrevocably assign to the provider/entity references above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my plan as payment towards the total charges for the services rendered. In addition, I agree and understand that nay funds I received by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

Acknowledgement of Financial Responsibility

I acknowledge that I understand the above information regarding the network status of the various services and Providers provided by Madison Medical & Sports Rehabilitation Center. I am aware I should contact my insurance carrier to identify specific coverage of my plan and potential costs. I understand I am knowingly and willingly accepting all financial responsibility associated with care, services, and treatment provided which are not covered by my insurance plan or for which I am responsible for payment under my insurance plan. To the extent no coverage exists under my insurance plan, I acknowledge I am responsible for all charges for services provided and agree to pay all changes not covered by my insurance plan.

A photocopy of this Assignment shall be considered as effective and valid as the original.

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Print Patient Name   Print Name of Guardian if applicable

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Patient or Guardian Signature   Date