FINANCIAL AGREEMENT

FINANCIAL RESPONSIBILITY

I understand my co-payment is due and payable at time of service. I am directly, completely, and fully responsible to EXCEL Therapy Specialists, LLC for physical therapy bills submitted for services rendered me and that this agreement is primarily for EXCEL Therapy Specialists' additional protection beyond any lien being filed and financial responsibility being served in consideration of their awaiting payment.

CO-PAY / CO-INSURANCE: _____ DEDUCTIBLE: _____ OTHER: _____

Finance charges of 10% per month, will accrue on the unpaid balance over 12 months and these charges will be included in the payment in full. Should my account exceed 60 days without insurance payment, I agree to pay my account in full or request a meeting with the Business Officer Manager of EXCEL Therapy Specialists, LLC to extend credit at which time I agree to make monthly payments. The payment amount will be determined at that meeting. There will be a $25.00 charge for all returned checks.

ASSIGNMENT OF PROCEEDS

I agree to an assignment of proceeds of any monies received by me or on my behalf with respect of my treatment for this accident, injury or illness. This includes, but is not limited to, any settlement, claim, judgment, verdict or partial settlement which occurs with respect to this accident, injury or illness. I further authorize and direct you, my insurance carrier, third party administrator and attorney to pay directly to EXCEL Therapy Specialists, LLC the monies due for services rendered to me, and to withhold such sum from any settlement, (either full or partial) claim, judgment or verdict as my be necessary to protect EXCEL Therapy Specialists, LLC adequately.

AUTO ACCIDENTS

I understand if I received physical therapy as a result of injuries sustained in an auto accident or this is a third party liability case, and I have requested EXCEL Therapy Specialists, LLC extend credit until settlement, EXCEL Therapy Specialists, LLC will file a lien on the settlement. I understand the statutory filing fees then in effect will be added to my account. I further understand that my obligation to pay my bill is not contingent on any settlement, claim, judgment or verdict by which I eventually may recover such fees. Should I request my medical insurance be billed and the third party insurance allows a higher rate than my medical insurance, I understand the larger allowed will be collected by EXCEL Therapy Specialists, LLC. I further agree that I will instruct all representatives or attorneys to fully pay the amount owed to EXCEL Therapy Specialists, LLC for services without reduction of any type. If agreed upon, I will make monthly payments until the account is paid in full.

COLLECTION PROCEEDINGS

Should my account become delinquent, I will be responsible for additional expenses to collect on my account, including reasonable legal fees, collection costs, and other expenses reasonably incurred.

NOTIFY OF CHANGES

I will notify EXCEL Therapy Specialists, LLC of any changes in address, employment or attorney representation within 10 days of the change.

BENEFIT ASSIGNMENT & RELEASE OF INFORMATION:

I hereby assign all medical and/or physical therapy benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to EXCEL Therapy Specialists, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party Signature: _____ Date:_____

IF PATIENT IS UNDER 18, LEGAL GUARDIAN MUST ALSO INCLUDE THE FOLLOWING INFORMATION AND ACKNOWLEDGE RECEIPT OF THIS NOTICE.

Relationship to Patient: _____ Date of Birth:_____ Social Security #: _____