Assignment & Financial Policy

I hereby instruct and direct my insurance company to pay by check made out and mailed to: Coastal Therapy, Inc. 911 East 70th Street, Savannah, Georgia 31405.

I hereby instruct and direct you to make the check(s) payable to Coastal Therapy, Inc. for the professional/ medical expense benefits allowable, and otherwise payable under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Coastal Therapy takes great pride in the high-level quality of services they provide. You've made an excellent decision by choosing to resolve your pain and problem with Coastal Therapy. In order to provide you with the best possible care, please review the following policies.

- Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.
- We accept cash, checks, MasterCard, Visa, and American Express.
- Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.
- No show appointments and / or appointments not cancelled within 24 hours are subject to a $25 charge.

We are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that: Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. We encourage you to review and understand your benefits as outlined by your insurance carrier. Benefits vary depending on the insurance company. Therefore it is the insured's/patient's responsibility to verify coverage. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

I agree that if my bill has to be turned over to a third party collection agency for non payment, there will be a collection fee added to my bill of thirty-three percent. This is pursuant to Georgia Statutory Law O.C.G.A. 13-1-11.

This financial form will also act as a promissory note between Coastal Therapy, Inc. and myself. Terms and conditions are as follows: I agree to pay any and all fees related to total charges for the professional services rendered by Coastal Therapy, Inc. I agree to pay in full all fees if I miss even one payment by one day I will then be in default and the entire balance will be due in full. This is pursuant to, and complying with Federal Statutory, Law and Commercial Code Section 15U.S.C.363 (a). The undersigned covenants and warrants that the indebtedness outlined in this promissory note is true and correct, and that the same is duly owed by the guarantor together with interest and collections fees.

I have read and agree to strictly abide by the terms and conditions of this document.

If you have any questions about the above information or any uncertainty regarding your insurance coverage PLEASE don't hesitate to ask us. We are here to help you.

Dated this _____ day of _____, 201___.

_____ _____

Signature of Patient/Guardian/Guarantor Witness

_____

Notary Public