Kascel Therapy LLC

Patient Financial Responsibility Disclosure and Acknowledgment

Your signature on the line below forms a legally binding agreement between Kascel Therapy, LLC and the undersigned patient (the "Patient") who is receiving medical services, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills associated with the medical services provided by Kascel Therapy, LLC, and is the individual indicated on the form below as the Responsible Party in the space provided. **All charges for services rendered are due and payable at the time of service.**

Kascel Therapy, LLC has contracts with numerous third-party insurance companies and Kascel Therapy, LLC will bill such third-party insurance companies for services rendered to you by Kascel Therapy, LLC as a service to you. The Responsible Party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason whatsoever. The Responsible Party shall also be responsible for making any and all required co-pays and deductibles. The Responsible Party shall also be responsible for paying any additional amount owing after claim submission to the Patient's insurance and will be billed for any such deficit after Kascel Therapy, LLC receives an explanation of benefits (EOB) from the Patient's insurance company.

The Responsible Party shall:

- Provide, and update to maintain current, the Responsible Party's current address and phone number for both the Responsible Party and the Patient.
- Present all current insurance cards prior to each of the Patient's office visits.
- Verify at each office visit that the information, including address, phone number, and insurance information is accurate and current by signing Kascel Therapy, LLC's data sheet.
- Pay any required co-pay at the time of each office visit.
- Pay any additional amount owing within thirty (30) days of receiving a statement from Kascel Therapy, LLC; it being understood that Kascel Therapy, LLC will bill the Responsible Party for any amounts not paid by the insurance company as set forth on the EOB received from the Patient's insurance company.

Non-Payment – In the event that Kascel Therapy, LLC should initiate collection proceedings or other legal action to collect an overdue account, the Patient and Responsible Party each acknowledge and understand that Kascel Therapy, LLC has the right to and shall disclose to its outside collections agency all relevant personal and account information necessary to collect payment for services rendered, including any applicable service charges and applicable costs of collections. The Patient and the Responsible Party each understand and acknowledge that they are responsible for all costs of collection, including without limitation attorneys' fees and costs, and that interest shall accrue on all unpaid balances at the rate of 18% per annum until repaid in full.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the Responsible Party, as applicable. Your signature below verifies that you have read the above disclosures, understand your responsibilities, and agree to the terms set forth herein.

Patient Name (Print): _____

Patient Signature: _____ Date:_____

Responsible Party Name (Print): _____

Responsible Party Signature: _____ Date:_____