Statement of Financial Responsibility

Madlena Performance Therapy is concerned about your health. We look forward to assisting you with your health care issues. Please remember that your health insurance is your responsibility, but we can help. Regardless of what we might calculate as your healthcare benefit in dollars, we must stress the fact that you, the patient, are responsible for the total treatment fee. As a courtesy to you, we can accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. We allow 90 days for your insurance company to make a payment. After that time all inquiries or follow up in payments due become your responsibility.

_____ _____

Patient/ Guarantor Signature Date

IF YOU RECEIVE MEDICARE, PLEASE READ THE FOLLOWNG, SIGN, AND, DATE

PATIENTS MEDICARE AUTHORIZATION

Patient's Name: _____

Patient's Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on behalf to:

Madlena Performance Therapy

for any services furnished me by that physicians/supplier. I authorize any holder or holder of medical information about me, to release information to the Health Care Financing Administration and its agents, any information needed determine these benefits payable to relatable services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If (other than insurance) is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient/Guardian Signature Date