P.O. Box 670207 Marietta, GA 30066
Office 678-503-8702, Fax 678-503-8912
www.koolkidzpt.com

FINANCIAL AGREEMENT, GUARANTEE OF ACCOUNT

The undersigned agrees that in consideration of the services rendered to the patient, he/she hereby obligates himself/herself to promptly pay the account of Kool Kidz, Inc. in accord with the regular rates and terms of the practice. I understand that physical/occupational therapy services are rendered and charged to the patient and not to the insurance company. Kool Kidz, Inc. cannot accept total responsibility for collection for your claim nor for negotiating a disputed settlement. Please be advised: We bill insurance as a courtesy. Verification of benefits is not a guarantee of payment. You are ultimately responsible for all charges if insurance does not cover or pay.

I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS.

Guarantor Signature _____ Date _____

Relationship to Patient _____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize medical payment directly to Kool Kidz, Inc. of any health insurance benefits payable to me, including medical insurance, but not to exceed the regular charge for services rendered to:

_____ Patient's Name

I hereby authorize Kool Kidz, Inc. to release information about this treatment/account to any person or corporation, including but not limited to, insurance carriers, welfare programs, or the patient's employer as necessary to secure timely payment.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENT AND ACCEPT ITS TERMS.

Signature of Insured _____ Date _____

Relationship to Patient _____