Patient Name:

KASSIMIR PHYSICAL THERAPY, PA
AGREEMENT TO PAY

THIS FORM IS NOT TO BE ALTERED BY PATIENT/REPRESENTATIVE FOR ANY REASON

I, _____, the undersigned, in consideration of the Physical Therapy services rendered by Kassimir Physical Therapy, P.A. (hereafter referred to as KPT), its Registered Physical Therapists, and/or its associates and employees, do understand that I am fully responsible for the payment of all charges for services rendered (if patient is a minor, the parent's or legal guardian's signature acknowledges such responsibility).

In the event that these services were rendered as a result of injuries sustained in an accident (Worker's Compensation or Motor Vehicle) occurring on _____ (date of injury) *(do not fill in if not applicable)*, I do hereby authorize and direct my attorneys, and all sources of benefits to which I am entitled (including, but not limited to, Worker's Compensation benefits, Personal Injury Protection proceeds, etc) to deduct from my portion of the proceeds of any recovery which may be paid to me through my attorney, and to promptly pay directly to KPT those sums of money due and owing as a result of the aforementioned professional services.

I understand that I am fully responsible for the payment of all charges, except compensable Maryland Worker's Compensation claims for services rendered, regardless of when or whether I receive any recovery of benefits as insufficient to satisfy such charges. I hereby waive any defense of statute of limitations as to any payments due KPT. In addition, I agree to pay any and all reasonable attorney fees, suit fees, etc., incurred on my account as assessed by KPT, as a result of any failure to pay this bill.

If my insurance payment has not been received within 60 days of the last claim, the full balance will be turned over directly to me, unless satisfactory arrangements have been made.

If I think my bill is incorrect, or I need more information about my bill, I will contact KPT as soon as possible. I understand that my insurance benefits have been verified by KPT as a courtesy to me, with no guarantee that the benefits information given to KPT on my behalf is 100% accurate. I understand that I am responsible for knowing and abiding by the requirements and limitations of my insurance benefits, and that I am responsible for making any required co-payment, co-insurance or deductible payments at the time of service, and am ultimately responsible for any balance remaining on my account after all insurance payments have been made.

I hereby authorize KPT to furnish to my attorneys, or to any insurance company representative, copies of any and all bills and reports they may request pertaining to professional services rendered to me for which a fee may be requested. A photocopy of this Agreement shall be considered as valid as the original and, therefore, may be used in place of the original.

I hereby acknowledge that I have been given ample opportunity to read the contents of this Agreement, have had the same thoroughly explained to me, and/or have had the opportunity to consult counsel of my own choosing to explain the contents of same, and/or answer questions that I may have as to the legal effect of this Agreement.

_____ _____

Patient/Guardian's Signature (SEAL) Date

_____ _____

Witness Date