CHANDLER BUSINESS GROUP,LLC
5284 Floyd Rd SW Unit 2105 Mableton GA, 30126
Telephone: (678) 361 1329

PAYMENT POLICY FORM

PAYMENT We will bill your CREDIT CARD for your purchase today. There is a non refund on this purchase, all sales are final.

In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements with you. Please be advised that *CHANDLER BUSINESS GROUP, LLC* is not a credit grantor, and therefore, failure to maintain these arrangements will result in the placement of your account with a collection agency or attorney for collection. Credit cards are accepted for payment on account.

_____**ADMIN FEE** We will bill you an Administration fee for processing your credit card at a charge of 3.5%. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

1. Do not qualify for benefits under any insurance policy (medical or auto), and
2. Are indigent and cannot pay for charges due using cash or credit card, and
3. Are awaiting settlement and subsequent payment of damages from a related legal case, and
4. Return our lien, signed by both you and your attorney.

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 60 days from the date of the last treatment. Upon settlement of your legal case, your balance is due in full within 30 days. Please be aware that you will remain financially responsible for services rendered regardless of the payment option

selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over 30 days old, charge returned check fees as allowed by state law, and charge a no-show fee for missed appointments when adequate notice of cancellation is not provided. Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize *Advance Physical Therapy & Sports Rehab, LLC* to treat the minor patient named in the attached consent form while I am not present.

CANCELLATION POLICY: To maintain appointment times available for all of our patients, there is a charge of $40.00, *BILLED TO THE PATIENT,* for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice. Patients who incur two NO SHOW/NO CALL incidents will be discharged from physical therapy services.

☐ Checking this box indicates that the formal office **HIPAA policy and procedures** have been explained to the above-noted patient and that a copy of the policy was provided to the patient.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to Advance P.T. & Sports Rehab, in the event they file insurance on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is there in default of payment I accept responsibility for the principal amount owing as well as reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fee, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Advance P.T. and Sports Rehab as maybe dictated by prudent medical practices by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

_____ _____

AUTHORIZED SIGNATURE DATE