OUTPATIENT THERAPY AGREEMENT

Date: ________________
Friendship Outpatient & Wellness Services, Inc ("Friendship")
_________________________________________ ("Patient")
_________________________________________ ("Responsible Party", if other than Patient)

1 - CONSENT FOR TREATMENT
   A. Patient consents to receive therapy services provided by Friendship as directed by the Patient's physician and as required by law for the health, welfare and benefit of the Patient.
   B. Patient agrees to abide by all policies established by Friendship for the operation of the therapy clinic.
   C. Patient consents to the release of their protected health information from the designated records set for the purposes of treatment, payment, or health care operations to the following persons: appropriate Friendship personnel, attending physicians and consultants; any person or firm responsible for all or any part of the payment or reimbursement of the charges; personnel of another health care provider to which Patient may be transferred; Friendship's liability insurance carrier; persons authorized by law to review the records; others necessary for treatment, payment, or health care operations; and such other parties as contemplated or authorized by federal or state law.

2 - ASSIGNMENT OF BENEFITS – Patient authorizes Friendship to bill directly to and collect payments directly from Patient's insurance company or the Medicare program on Patient's behalf for all services provided to Patient.

3 - BILLING FOR SERVICES
   A. If part or all of the therapy services provided by Friendship are not covered under the Medicare program or by the Patient's commercial insurance policy, then the Patient and/or Responsible Party shall pay for the therapy services rendered when billed. Services will be billed at the standard charges as shown on the Rate Schedule then in effect.
   B. Commercial insurance coverage is an agreement between the Patient and the insurance company. Friendship may file claims on behalf of the Patient or assist in filing claims. However, the Patient is responsible for the payment of all charges billed to a commercial insurance carrier that are not paid by the insurer. Any insurance payment received directly by Patient shall be paid to Friendship for services billed to the insurance company.
   C. All applicable coinsurance and deductible amounts under either the Medicare program or a commercial insurance company are the responsibility of the Patient, and shall be due and payable at the time therapy services are rendered, unless such coinsurance and deductible amounts under the Medicare program are billable to the Patient's commercial insurance company.
   D. If the Patient is in a Home Health episode at any time Friendship provides services, then the Patient will be responsible for payment of all charges unless an arrangement is made in advance with the Home Health Agency to cover the treatments and to pay Friendship directly.

4 - PAYMENT POLICY
   A. The Patient and/or Responsible Party shall make prompt payment to Friendship of all charges due.
   B. If the Resident and/or the Responsible Party fails to pay any fees and charges due Friendship by the 15th of the month, a late charge in the amount of five percent (5%) on any new unpaid balance shall be imposed.
   C. The Patient and/or Responsible Party acknowledge that a credit report may be obtained as part of the collection process.
   D. The Resident and/or Responsible Party shall be liable for any fees for returned items charged to Friendship by its bank plus a processing charge of $25.00.
   E. Therapy treatment may be discontinued for nonpayment.
   F. If the account is placed for collection in the hands of a collection agency and/or an attorney, the Patient and/or the Responsible Party shall pay all collection agency charges and other collection expenses including but not limited to a reasonable attorney's fee (with the sum of twenty-five percent [25%] deemed reasonable) and court costs.
5 - REFUNDS - Refunds of any amounts paid in excess of the charges will be made by Friendship after all outstanding insurance claims have been collected.

6 - FUTURE SERVICES - If services to the Patient are discontinued, this agreement will still apply to any subsequent services rendered, should such services occur within 30 days of the date services were discontinued.

7 - RESTRICTIONS AND LIABILITIES –
   A. The Patient's failure to accept any therapy treatment, medical or other treatment, or other item or service that is deemed necessary and proper by Friendship shall release Friendship from any liability which may result from lack of such care, treatment, item or service.
   B. Friendship shall not be liable for injuries of any kind suffered by the Patient while under its care, except where injury is caused by the negligence of Friendship or its officers, employees or agents.
   C. The Patient and/or the Responsible Party shall indemnify and hold Friendship and its officers, employees and agents harmless from and against any liability for personal injuries, property damage caused by the Patient.

8 - OTHER PROVISIONS –
   A. This Agreement shall be for the benefit of and shall be binding upon the parties hereto and their respective representatives, successors and permitted assigns.
   B. None of the provisions of this Agreement shall be considered waived by any party unless the waiver is given in writing signed by all of the parties. The failure of any party to insist upon strict performance of any of the terms or conditions of this Agreement, or failure or delay to exercise any rights provided herein or by law, shall not be deemed the waiver of any rights of any parties.
   C. If the final determination of a court of competent jurisdiction declares, that any term or provision hereof is invalid or unenforceable, (i) the remaining terms and provisions hereof shall be unimpaired.
   D. Auxiliary Aids and Services for persons with disabilities and/or limited English proficiency are available through the Outpatient Coordinator, (540) 265-2199.
   E. Friendship Outpatient & Wellness Services does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact:
      Corporate Compliance Officer (540) 265-2222

PATIENT

Verification that home health services are not being provided.

Printed Name: ________________________________

Signature of Patient, Guardian, or Power of Attorney:

______________________________ Date: __________

RESPONSIBLE PARTY

Verification that home health services are not being provided.

Printed Name: ________________________________

Signature: ________________________________ Date: __________

FRIENDSHIP REPRESENTATIVE

Printed Name: ________________________________

Signature: ________________________________ Date: __________
9 - CANCELLATION/NO-SHOW POLICY – Friendship Outpatient & Wellness Services reserves the right to charge $25 for appointments that are cancelled with less than 24-hours notice and $30 for no-shows. This is an out-of-pocket fee that will not be covered by insurance. In addition, if you do not show for 2 consecutive appointments, all future appointments will be placed on hold. You will need to contact our office to reschedule.

If you are more than 15 minutes late to your appointment, you will need to reschedule for another day.

PATIENT
Printed Name: ____________________________________________
Signature of Patient, Guardian, or Power of Attorney: 

RESPONSIBLE PARTY
Printed Name: ____________________________________________
Signature: ____________________________________________ Date: _________

FRIENDSHIP REPRESENTATIVE
Printed Name: ____________________________________________
Signature: ____________________________________________ Date: _________