HARMONY UNITED PSYCHIATRIC CARE

Financial Agreement

1. FINANCIAL AGREEMENT

The undersigned agrees as the agent of, or as Patient, that in consideration of the services to be rendered to the patient, he or she individually obligates himself or herself to pay the account of Harmony United Healthcare and Research, P.A. d/b/a Harmony United Psychiatric Care ("Harmony") in accordance with the regular rates and terms of Harmony. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the current FL legal rate of 9.0%.

2. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes as the agent of, or as Patient, direct payment to Harmony of any insurance benefits otherwise payable to or on behalf of the Patient for this treatment, including emergency services if rendered, at a rate not to exceed the Harmony's regular charges. It is agreed that payment to Harmony, pursuant to this authorization, by an insurance company shall discharge such company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he or she is financially responsible for charges not covered by the assignment.

3. HEALTH CARE SERVICE PLAN OBLIGATION

Harmony maintains a list of health service plans with which it has contracted. A list of such plans is available on request. Harmony has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he or she is individually obligated to pay the full costs of all services rendered to him or her by Harmony if he or she belongs to a plan which does not appear on the above-mentioned list.

Please read and respond to the following statements regarding advance directives (durable power of attorney for health care or living will):

Please Confirm:

☐ I have received information about my right to make decisions regarding my medical treatment, my right to formulate advance directives in the case of my subsequent incompetency, and Harmony's policies on the implementation of these rights.

Do you have an Advance Directive for healthcare or Durable Power of Attorney for Healthcare or Living Will?

☐ Yes
☐ No

Has Harmony received a copy of your Advance Directive prior to this visit?

☐ Yes
☐ No

301 Skyline Drive, Suite 4, Lady Lake, FL 32159
Phone: (352) 431-3940 | **Fax:** (352) 431-3173 | **www.hupcfl.com**

If Harmony has not received a copy of my Advance Directive for healthcare or Durable Power of Attorney for Healthcare or Living Will, I understand it is my responsibility to present a current copy on each visit.

THE UNDERSIGNED (THE PATIENT) CERTIFIES THAT I HAVE READ THE ABOVE PROVISIONS OF THIS AGREEMENT, RECEIVED A COPY OF THIS AGREEMENT, AND I AM DULY AUTHORIZED TO EXECUTE THE ABOVE AGREEMENT AND TO ACCEPT ITS TERMS.

Date : _____

Time :_____

Patient Name :_____

SSN :_____

Signature :_____

In the presence of:

Witness Signature : _____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT, OR THE PATIENT'S LEGAL REPRESENTATIVE:

I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the Financial Agreement, assignment of insurance benefits, and health care service plan obligation provisions (SECTIONS ONE, TWO, and THREE, respectively) of the above agreement.

Responsible Party/Guarantor : _____

SSN :_____

Signature : _____

In the presence of : _____
Print Name

Witness Signature : _____

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