HARMONY UNITED PSYCHIATRIC CARE

Financial Agreement

1. FINANCIAL AGREEMENT

The undersigned agrees as the Client/Patient, or Parent/Legal Representative acting on behalf of the Client/Patient, that in consideration of the services to be rendered to the Client/Patient, the Client/Patient or Parent/Legal Representative 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 Client/Patient 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 Client/Patient, or Parent/Legal Representative of Client/Patient, to direct payment to Harmony of any insurance benefits otherwise payable to or on behalf of the Client/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 upon request and online. Harmony has no contract express or implied with any plan that does not appear on the list. The undersigned agrees that they are individually obligated to pay the full costs of all services rendered to him or her by Harmony if they belong to a plan that 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):

I, the Client/Patient or Parent/Legal Representative of Client/Patient, understand that I have the right to make decisions regarding my Child's/Client's medical treatment and I, the Client/Patient, have the right to formulate advance directives in the case of my subsequent incompetency.

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

☐ Yes ☐ No

Has Harmony received a copy of your or your Client's Advance Directive prior to this visit?

☐ Yes ☐ No

If Harmony has not received a copy of the 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 Client/Patient or Parent/Legal Representative) 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:_______________________

Client/Patient Name (Print):____

Signature:____________________________________ SSN:____________________________________

Financial Responsibility Agreement by Person Other Than the Client, or the Client's Legal Representative

I agree to accept financial responsibility for services rendered to the Client/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.

Date: ___________________________ Time:_______________________

Responsible Party/Guarantor (PRINT NAME): ____

Signature: ____________________________________ SSN:____________________________________