Physical Medicine Associates, Inc.

3555 Olentangy River Rd, Ste 1010
Columbus, OH 43214

340 E. Town St., 8-700
Columbus, OH 43215

7269 Sawmill Rd, Ste 150
Dublin, OH 43016

Patient Contract

The following document serves as an agreement between the Physicians and staff of Physical Medicine Associates, Inc. and the patient.

Physical Medicine Associates, Inc.'s mission is to provide quality services to our patients. We strive to improve the quality of service to our patients and to provide our patients prompt and courteous service.

In order for Physical Medicine Associates, Inc. to be able to provide quality care to our patients, we feel the following terms are necessary from our patients:

I _____ understand that as the recipient or the guardian of the recipient of medical care, I, the undersigned, am responsible for scheduling my appointments at convenient times and if I am unable to keep my appointment with my doctor, it is my responsibility to contact the office at least 24 hours in advance to cancel or reschedule my appointment. I understand that if I fail to give the office at least 24 hours notice, and if I have 2 such cancelations within 12 months, I will be charged a $25 fee, which must be paid prior to my scheduling another appointment. I understand that if I am receiving prescriptions from my doctor, it is my responsibility to schedule and keep my appointments as directed by my doctor and that if I fail to do so, my doctor will not be able to prescribe my medications. If I am receiving medications from my doctor, I understand and agree that the office will need five (5) working days for medication refill requests.

I understand that it is my responsibility to provide Physical Medicine Associates, Inc. with my correct contact information and correct insurance information at each visit. I understand that if an insurance claim is rejected because of incorrect information provided (or failed to provide), I am responsible for payment in full for any charges, regardless of the provider status of my doctor. ***I understand that I must provide a state issued ID, my insurance card, along with the subscriber's name, date of birth AND Social Security Number, as well as the patient's Social Security Number for billing purposes.*** I also understand that my copay is due at each visit and if I am unable to pay this at the visit, I may have to reschedule the appointment. As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note, your health insurance is a contract between YOU and YOUR INSURANCE COMPANY, so it is your responsibility to ensure that our physicians are covered under your plan. Not all insurance companies carry the same benefits, so the services rendered to you in this office may or may not be covered. It is the patient's responsibility to know what is covered and if you need a referral.

I hereby authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims and/or to release medical information, as outlined in my contract with my insurance company, to obtain benefits for services rendered.

I hereby authorize my insurance company to pay and hereby assign directly to Physical Medicine Associates, Inc. all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by Physical Medicine Associates, Inc. will be credited to my account in accordance with my insurance company's assignment if my doctor is a provider for my insurance company. Any unpaid charges or fees for out of network service or non-covered services, regardless of the reason they are non-covered, are my responsibility.

I understand that Physical Medicine Associates, Inc. does NOT accept HCAP that is offered through the hospital. I understand that by keeping my appointment, I will be responsible for the balance of my visit after insurance payments and adjustments.

I agree to make prompt payments for services rendered by Physical Medicine Associates, Inc. . I understand that if I am unable to pay the balance promptly, it is my responsibility to contact Physical Medicine Associates, Inc. to set up a payment plan. I understand that if I fail to make prompt payments or fail to adhere to the payment plan, my account may be turned over to a collection agency. If this is necessary, I will be responsible for any collection fees, attorney fees or any additional fees related to collecting my balance due. I agree that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

I understand that if I have any questions about my responsibilities or this agreement, I am responsible for contacting Physical Medicine Associates, Inc. with my questions.

I have read and agree to the terms outlined above.

Signed (Patient or Guarantor) _____ Date _____

Printed Name _____

Patient Name (If different) _____