FAIRVIEW

TRUSTED FOR GENERATIONS

Outpatient Rehabilitation Services

Agreement to Pay Non-Covered Therapy Services

I understand that I am personally responsible for any Physical Therapy, Occupational Therapy, or Speech Therapy services not covered by my insurance (Medicare, Medicare HMO, Commercial insurance, etc.). My signature shows that I understand that payment is due in full within 30 days of date of billing unless other financial arrangements have been made prior to treatment. I understand I may be subject to attorney fees and collection costs in the event of default of any charges.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Date