9 East High St. (Rear) . Carlisle, PA 17013 . (717) 440-0498 . FAX (717) 918-5784

Patient Name_____DOB_____

FINANCIAL PRACTICES

ASSIGNMENT OF BENEFITS: In consideration for services and treatment rendered, I hereby assign, transfer and set over onto BrightStar Health and Wellness Services in MA and/or Peaceful Balance Health and Wellness Services in PA (AKA "The Practice"), all health insurance, workers compensation, and automobile insurance, all 3rd party payment or any other benefits of any nature whatsoever due to and payable to me including personal injury protection, medical payments, underinsured/uninsured benefits and any other benefits, and any other coverage which becomes available to me. I hereby direct my insurance company to make all payments I may be entitled to directly to "The Practice".

APPLICABLE TO MEDICARE BENEFICIARIES ONLY: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration or its intermediaries or carries of any information needed for this or a related medical claim is true and correct.

FINANCIAL RESPONSIBILITY: I understand and agree: I am responsible for my and my dependents fees to The Practice including any fees not paid by medical insurance that is not paid when the account is due. Reasonable collection and court costs will be paid by me at the interest rate of 3% per month and will be charged on an outstanding balance after 90 days. I am responsible for missed appointment fees resulting from no-show appointments and late cancellations (without 24 hour notice) at the discretion of the providers at "The Practice". Fees for services must be paid for at the time of service and that I am responsible for filing for insurance reimbursement. (Medical Records will not be released until all outstanding balances are paid in full.)

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLES: I understand that my insurance may not cover 100% of the fees that are charged when accessing healthcare at "The Practice". I also understand that my insurance coverage is a contract between myself and the insurer. The Practice is billing insurance on my behalf for services rendered by the providers employed there. I understand that "The Practice" is not responsible for my insurance benefits. I understand that it is my responsibility to understand my insurance plan. "The Practice" cannot advocate on my behalf with my insurance company, but they may assist with providing billing codes (CPT) and diagnosis codes (ICD-10) codes when submitting bills on my behalf. I understand that I may have personal responsibility for co-pays, co-insurance, and deductibles when they are part of my insurance coverage. I understand that by law I must pay these fees to "The Practice" when required by my coverage. I understand that these fees must be paid prior to a scheduled appointment when the amounts can be verified, this includes co-insurance and deductible amounts.

NO-SHOW FEES: No-show or late cancellation fees will be charged when I "no-call, no-show" for a previously scheduled appointment or provide less than 24 hour's notice that I am unable to make an appointment. No shows fees will be posted in the check-in area. This fee can be waived as the discretion of the Provider or Office Manager. No show fees must be made before additional appointments are scheduled.

EQUIPMENT OR SUPPLIES: Any equipment or supplies provided to me by "The Practice" remains the property of "The Practice" unless otherwise designated by "The Practice". I understand that it is my responsibility to keep the equipment or supplies in proper working order and if any problems occur to notify "The Practice" immediately and return said equipment or supplies to "The Practice" for repair or exchange. I agree that should I fail to care for the equipment or supplies in a reasonable manner, or if I not comply with the parameters necessary to participate or I should electively discontinue participation in the program I must return said equipment or supplies within 30 days or I will be responsible for the cost of the equipment or supplies. Should "The Practice" request return of the equipment or supplies I understand that I have 30 days to return the equipment or supplies or I will be responsible for their cost.

Signed_____ Date_____

"The Practice"
Representative_____

I understand that I can revoke this consent in writing, except to the extent that "The Practice" has already taken action in reliance on it. I understand that if I revoke this consent "The Practice" may refuse to provide me with treatment. I also understand that this consent authorizes "The Practice" to use and disclose all past information documented in my medical record in accordance with the Privacy Notices provided. _____Initials