PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing ProHealth as your healthcare provider. The medical services you seek imply financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. By signing below and/or by receiving medical services from ProHealth you agree:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services immediately.

2. You will be required to follow all registration procedures, which may include updating or verifying personal information. As a self-paying patient, our fee is expected to be paid in full at the time of service. If you are not prepared to make your patient responsibility amount, your visit may be re-scheduled.

3. We accept payment by check, cash, debit cards, and the following credit cards:

    - Mastercard, VISA, MC, American Express & Discover

4. **Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize ProHealth, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). PLEASE NOTE: The above language authorizes an electronic debit to your account for the check plus the state-allowed recovery fee. In accordancewith the rules of the National Automated Clearing House Association (NACHA), this authorization is to remain in effect until ProHealth has received written notice of termination in such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that ProHealth cannot collect a returned check fee by other methods.

5. **Payment by Credit Card/Debit Card.** You may pay with a credit card or debit card, and that payment maybe made in person, by mail, or by calling the number provided on your billing statement. All regular credit card rules will apply. Once authorization on the submitted information is received, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment. While processing your credit card payment, only 1st 5 and the last 4 numbers of your credit card are viewable by ProHealth personnel. We do not otherwise store your sensitive credit card information. ProHealth will allow you to choose to use your FSA or HSA funds to pay for any ProHealth service.

6. **Non-payment on Account.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that ProHealth has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law,and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account and is not deemed interest as part of a credit transaction.

Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the ProHealth PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to ProHealth for the below Patient's care and treatment, (iv) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____	_____	_____
Patient/Responsibility Party/Guardian	Date	Date of Birth