



## FINANCIAL RESPONSIBILITY AGREEMENT

I, \_\_\_\_\_, understand that I am responsible for all charges incurred for my treatment at *Bodyworks Therapy*. I consent that medical benefits from my insurance policy are paid directly to *Bodyworks Therapy*, in consideration of services rendered up to the total amount of my account.

Any balance remaining after insurance benefits have been paid is my responsibility. I will pay the balance within 60 days unless other arrangements have been made. I understand that in the event of default, my account will go to a collection agency. It is my responsibility to provide the correct insurance information. I will pay any balances resulting from inaccurate insurance information and I understand that I am responsible for all remaining balances. Every possible effort will be made to obtain payment for my claims. If the insurance company does not respond within 60 days I will pay in full and submit my receipt to get reimbursed from my insurance company. \_\_\_\_\_(initial)

### **MVA / Personal Injury**

I hereby authorize *Bodyworks Therapy* to furnish you, the insurance company, a full report of their examination, diagnosis, and prognosis of my injuries, arising from the accident in which I was involved.

I further authorize and irrevocably direct you, the insurance company, to pay directly to *Bodyworks Therapy* such billings and fees as may be due and owing to them for services/treatment, and reports rendered to me due to this accident. I understand that *Bodyworks Therapy* will be filing a State recorded lien on my case against all proceeds of any settlements, judgements, dispositions, proceeds, payments or verdicts that may come as a direct result of this claim.

This contract is binding upon me, whether signed by my insurance company. A photocopy reproduction of this authorization and signature may be used in place of the original. \_\_\_\_\_(initial)

### **Attorney Agreement**

The undersigned, being the attorney of record for the above-mentioned patient, does hereby agree to observe all the terms of this Medical Authorization and agrees to withhold such sums in trust from any payments, proceeds, dispositions, settlements, judgements or verdicts as may be necessary to adequately protect *Bodyworks Therapy*. Counsel further agrees to notify *Bodyworks Therapy* in writing when this patient's case is transferred to a new attorney. The undersigned also represents and warrants to *Bodyworks Therapy* that he/she has explained fully to his/her client, all the legal ramifications of the foregoing lien for services rendered including, but not limited to, its irrevocability. Furthermore, counsel agrees that after receiving monies to send payment to *Bodyworks Therapy* within thirty (30) days. \_\_\_\_\_(initial)

ALL COPAY AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Appointments must be cancelled with 24 hours in advance. The fee for last minute cancelations is \$65.00.

# Bodyworks

## T H E R A P Y

I authorize the release records necessary to process insurance claims.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

### WAIVER OF ATTORNEY'S FEES REDUCTION & THIRD-PARTY SETTLEMENTS

Patient and Therapist hereby enter into an agreement as follows:

1. Patient is seeking treatment from therapist for injuries which give rise to a third party personal injury claim.
2. Therapist is entitled to payment at the time that services are provided.
3. Under AS 34.35.450.482, therapist may assert a Lien for unpaid medical charges against the liable party, the liable party's insurer and Patient's attorney.
4. Patient is entitled to a pro rata reduction of therapist Lien for attorney's fees and costs incurred in the pursuit of Patient's third party personal injury claim. ANMC v Settlement Funds, 2004 WL 179026 (Alaska, 1/30/04)
5. Therapist is willing to provide services without full payment at the time the services are rendered upon condition that Patient waives his/her right to reduce therapist Lien for costs and attorney's fees as set forth above.
6. By signing this Waiver, Patient acknowledges that his/her rights to pro rata reduction of therapist Lien for attorney's fees and costs incurred in the pursuit of Patient's third party personal injury claim have been explained to him/her.
7. By signing this Waiver, Patient agrees to waive pro rata reduction of therapist's Lien for attorney's fees and costs incurred in the pursuit of Patient's third party personal injury claim and to pay the therapist's Lien in full upon settlement of the third party personal injury claim.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_