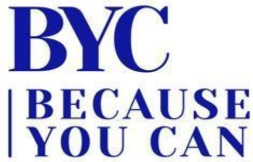

5225 Central Ave, Saint Petersburg, FL 33710

Financial Communications Form

Patient's name: ______________________________ **Date of birth:** ____________

Financial Agreement

- I acknowledge that, as a courtesy, Because You Can, LLC may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to, any copayment, coinsurance, and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Because You Can, LLC may use the services of a third party business associate or affiliated entity as an extended business office (EBO) servicer for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Because You Can, LLC any insurance or other third party benefits available for healthcare services provided to me. I understand Because You Can, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Because You Can, LLC, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefits. I certify that any information I provide, if any, in applying for payments under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on behalf of Because You Can, LLC by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Because You Can, LLC or EBO servicers and collection agents to service my account or collect any amounts I may owe, I expressly agree and consent that Because You Can, LLC or EBO servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, that I have provided; or Because You Can, LLC or EBO servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

A photocopy of this consent shall be considered as valid as the original.

____

Patient/Parent/Legal Guardian's signature *Relationship to patient, if not self* *Date*