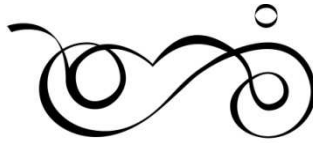


Winebrenner & Associates'



Charter Physical Therapy, LLC[®]
Setting Your Course for Recovery and Wellness

Financial Policy

We believe that everyone benefits when there is a definite and clear financial agreement prior to treatment. Our policy is as FOLLOWS:

You must furnish all necessary payment information prior to your first visit. This includes health insurance, auto insurance, workers compensation; personal injury and attorney information (if applicable). This allows us to verify your benefits, obtain necessary authorizations and avoid unnecessary or unexpected cost to you.

Please understand that a referral from your doctor may be necessary in order to submit claims to your insurance carrier. It is the patient's responsibility to obtain this referral. If a valid referral is not on file, then you will be required to either sign a voluntary waiver or reschedule your appointment.

If required by your insurance co-payment is due on date of service and will be collected at time of check-in. If applicable, you will be billed for any remaining coinsurance or deductible after charges have been processed by your insurance company.

If you are unable to keep a scheduled appointment, we require 24 hours notice (**410-526-0351** or **410-526-5307**), so that we may make the appointment time available to other patients. If the required notice is not given, then a cancellation charge of \$25 will be assessed to you, the patient, not billed to your insurance company. **Fee will be due at your next scheduled appointment.**

All accounts with a balance over 30 days may be assessed a 1.5% late charge per month on the unpaid monthly balance. Payment plan can be arranged through the Billing Manager (**410-526-5307**). If an account becomes assigned to a collection agency, the patient will pay 100% of collection agency fees, 100% of court costs, and 100% of attorney fees.

I hereby certify that I have read and understand the financial policy of Charter Physical Therapy, LLC as put forth above and agree to all terms and conditions. I also authorize the release of any personal health information to my insurance company and any other health care professionals involved in my case.

Signature _____

Date _____

Print Name _____

Witness _____

Effective December 1, 2009