



Financial Agreement

Please read this Agreement carefully. We are happy to answer any questions you may have.

Please print legibly.

I, _____, as patient/parent/guardian of patient understand that my insurance is an agreement between the insurance company and myself. I authorize Manchester Bedford Myoskeletal LLC and Joel Kouyoumjian, LMT MMT, hereafter “*Provider*”, to submit claims on my behalf to my health insurance company, hereafter “*Insurer*”. I understand I am fully responsible for all payments due whether approved or denied by “*Insurer*” including “*Insurer*” requires return of overpayment or denies claims for any reason before or after payment is made.

I understand that I am responsible for any copayment and deductible amount required at the time of service under my insurance policy for services rendered.

I authorize any holder of information about me to release such information needed to determine eligibility and benefits or to assist in the collection of payment for services.

Out-Of-Network Payment Options:

I understand “*Provider*” is a Non-Participating Provider with “*Insurer*” and any claim submitted on my behalf may be paid, partially paid, or denied by “*Insurer*”. I further understand “*Insurer*” may make any reimbursement directly to myself or to “*Provider*”, depending on contract agreements “*Insurer*” has legally filed.

_____ (*initials*) I agree to pay for all services rendered in full at the end of each visit, **OR;**

_____ (*initials*) I give “*Provider*” permission to automatically charge my credit card on file monthly for all fees due for all dates of service in the billing period,

AND;

_____ (*initials*) In any case where “*Insurer*” or their agents and “*Provider*” agree to a negotiated payment for services on any given date of service, I will be responsible for any co-pay or co-insurance described in “*Insurer’s*” statement of benefits (EOB) and give “*Provider*” permission to automatically charge my credit card monthly for claimed amount for the period, **AND;**

_____ (*initials*) In the case where “*Insurer*” or their agents and “*Provider*” agree to a negotiated payment for services on any given date of service and that payment is **not** paid directly to “*Provider*” within the agreed upon time period, I will be responsible for the full claimed amount regardless of any negotiated and agreed upon rate and give “*Provider*” permission to automatically charge my credit card monthly for claimed amount for the period, **AND;**

_____ (*initials*) If “*Insurer*” reimburses “*Provider*” directly, I **agree / disagree** (*circle one*) to “*Provider*” holding reimbursed amount to be charged against my future visits until such time as I give in writing a statement canceling this agreement, at which time any balance held by “*Provider*” will be distributed back to me. If I **disagree** to this section, “*Provider*” will disburse all monies held in my account to me minus any amount I owe to me once “*Provider*” is reimbursed.

In the event any fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I _____ will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

Signature: _____ Date: _____

(Rev 05/02/2023)