Harmony United Psychiatric Care

Financial Agreement

This is a required form that must be completed for service

1. FINANCIAL AGREEMENT

The undersigned agrees as the Client/Patient or, Parent/Legal Representative acting on behalf of the Client/Patient, that in consideration of the services to be rendered to the Client/Patient, the Client/Patient or Parent/Legal Representative obligates himself or herself to pay the account of **Harmony United Healthcare LLC,** d/b/a Harmony United Psychiatric Care ("Harmony") in accordance with the regular rates and terms of Harmony. Should the account be referred to an attorney or collection agency for collection, the Client/Patient/Parent/Legal Representative agrees to reimburse Harmony the fees of any third-party debt collector and all costs and expenses, including reasonable attorney's fees, Harmony incurs in such collection efforts. All delinquent accounts shall bear interest at the current maximum rate allowed under Florida law of **12.0%**.

2. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes as the Client/Patient or Parent/Legal Representative of Client/Patient, to direct payment to **Harmony United Healthcare LLC** of any insurance benefits otherwise payable to or on behalf of the Client/Patient **for treatment,** including emergency services if rendered, at a rate not to exceed the Harmony's regular charges. It is agreed that payment to Harmony, pursuant to this authorization by an insurance company, shall discharge such company of any and all obligations under a policy to the extent of such payment. The undersigned understands that he or she is financially responsible for charges not covered by the assignment.

3. HEALTH CARE SERVICE (INSURANCE) PLAN OBLIGATION

Harmony maintains a list of health service (Insurance) plans with which it has contracted. A list of such plans is available on **r**equest and online. Harmony has no contract, expressed or implied, with any plan that does not appear on the list. The client/Patient or Parent/Legal Representative of the Client/Patient is solely responsible for verifying the benefits coverage under his/her health care service (insurance) plan. The undersigned agrees that they are individually obligated to pay the full costs of all services rendered to him or her by **Harmony if the** cost of the services is not covered by the health service (Insurance) plans. Please read and respond to the following statements regarding advance directives (Durable Power of Attorney for Health Care or Living Will):

I, the Client/Patient or Parent/Legal Representative of the Client/Patient, understand that I have the right to make decisions regarding my/my Child's/my client's medical treatment, and I, the client/patient, have the right to formulate advance directives in the case of my subsequent incompetency.

Do you or your client have an Advance Directive for healthcare or Durable Power of Attorney for Healthcare / Living Will?

Yes ☐ No ☐

Has Harmony received a copy of your or your Client's Advance Directive?

Yes ☐ No ☐

If Harmony has not received a copy of the Advance Directive for healthcare or Durable Power of Attorney for Healthcare or Living Will, I understand it is my responsibility to present a current copy.

I hereby expressly consent to allow Harmony, its affiliates, or agents (business associates and/or third-party agencies) to contact me (including, but not limited to through the use of contact information and/or telephone numbers that I have provided to Harmony or its affiliates, via telephone, text message, cellular device, electronic mail or fax, either through the use of a pre-recorded message, artificial voice, or auto/predictive dialing equipment. I agree that I can revoke my consent to receive such communication by providing a written statement of revocation to the business office of Harmony at the office address above. In the case of a text message, I can use the opt-out option in the text message. I agree that oral communications for revocations are not acceptable.

THE UNDERSIGNED (THE CLIENT/PATIENT OR PARENT/LEGAL REPRESENTATIVE) CERTIFIES THAT I HAVE READ THE ABOVE PROVISIONS OF THIS AGREEMENT, RECEIVED A COPY OF THIS AGREEMENT, AND I AM DULY AUTHORIZED TO EXECUTE THE ABOVE AGREEMENT AND TO ACCEPT ITS TERMS.

Date: ___________________________ Time: _______________________

Patient/Client (Print Name): ____

SSN (Client/Patient): ____

Telephone Number: _________________________

Cell ☐Yes ☐No

Parent/Legal Representative (Print Name if Applicable): ____

SSN (Parent/Legal Representative if Applicable): ____

Signature: ____

Client/Patient or Parent/Legal Representative

*Please Note! If the Client/Patient is a minor or unable to consent, then this form needs to be signed by a Parent or a Legal Representative.