Kirk Center for Healthy Living
Therapy for Pelvic Pain, Incontinence, Infertility and Gastrointestinal Disorders

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Phone: **(815) 838-0529** ❖ Fax: **(815) 838-0652**
Website: **kc4hl.com**

PATIENT SERVICES AGREEMENT

PATIENT NAME: _____

INSURANCE BENEFITS: After my deductible of $_____ has been met, estimated per visit amount to be paid by me will be $_____. I understand that I am responsible for the unmet portion of my deductible, and all charges that are not covered by my insurance company. I guarantee payment of my account in full to Kirk Center for Healthy Living, P.C. ("Kirk Center") and understand that I can make payment arrangements prior to my discharge from therapy.

ASSIGNMENT OF BENEFITS: I authorize payment of benefits be made directly to Kirk Center for Healthy Living for services rendered. I guarantee that I will immediately reimburse Kirk Center for Healthy Living for any benefits assigned to me.

PAYMENT GUARANTY: I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED BY KIRK CENTER WHICH ARE NOT PAID BY MY INSURANCE. I expressly guaranty payment of this account with Kirk Center, and agree to pay all charges that remain unpaid by my insurance company within 30 days of the invoice date for those services. Interest at the rate of 1.5% per month, or portion of a month, will be added to any past due balance. I also agree to pay all expenses incurred by Kirk Center, including reasonable attorney fees, to collect any past due balance owed to Kirk Center.

RELEASE OF INFORMATION: I authorize Kirk Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

PERMISSION FOR MESSAGES: I authorize Kirk Center to leave messages -

About my treatment:

☐ on my voicemail or answering machine at my home
☐ on my voicemail on my cell phone
☐ on my voicemail at my work
☐ with another person

About my appointment times:

☐ on my voicemail or answering machine at my home
☐ on my voicemail on my cell phone
☐ on my voicemail at my work
☐ with another person

I have read this agreement and understand my obligations

_____ _____
Patient/Insured's Signature Date

_____ _____
Patient Address Preferred Phone