SELF PAYMENT AGREEMENT

◯ I AGREE THAT FOR $500.00, I WILL RECEIVE 5 PHYSICAL THERAPY VISITS & ONE MONTH OF AFTER CARE. I AGREE TO PAY $100.00 WITHIN THE FIRST WEEK OF CARE, THEN $200.00 EACH MONTH THEREAFTER UNTIL MY ACCOUNT IS PAID IN FULL. **

◯ I AGREE THAT FOR $300.00, I WILL RECEIVE 3 PHYSICAL THERAPY VISITS & ONE MONTH OF AFTER CARE. I AGREE TO PAY $100.0 WITHIN THE FIRST WEEK OF CARE, THEN $100.00 THE FOLLOWING MONTH. **

◯ I AGREE THAT FOR $100.00, I WILL RECEIVE A FULL PHYSICAL THERAPY EVALUATION. I AGREE TO PAY $100 FOR EACH SUBSEQUENT VISIT. **

I AGREE TO PAY $_____

EVERY ____ VISIT ____ WEEK ____ BI-WEEKLY ____MONTHLY ____ UNTIL THE BALANCE IS PAID IN FULL. I AGREE IT IS MY RESPONSIBILITY TO MAKE TIMELY PAYMENTS AS AGREED FOR ALL SERVICES RENDERED. IF AT ANY TIME YOUR ACCOUNT BECOMES DELINQUENT, YOUR SELF PAY DISCOUNT WILL BE REMOVED AND YOUR BALANCE WILL RETURN TO THE FULL AMOUNT OF TREATMENT. ALL DELINQUENT ACCOUNTS WILL BE TURNED OVER TO A COLLECTION AGENCY.

**All of the above options come with ONE MONTH OF FREE AFTERCARE SERVICES. Aftercare includes full hour sessions with access to the clinic physical therapist on staff. The number of aftercare sessions is unlimited M-F for the full month. Please see the AFTERCARE Agreement and policy.

PATIENTS NAME_____

SIGNATURE OF RESPONSIBLE PARTY_____ **DATE**_____