Patient Care Insurance Agreement and Disclosure Of Financial Interest

In Consideration of your undertaking to care for me, I agree to the following:

1. **In the event any insurance company, obligated by contractual agreement to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you, or does not make payment within sixty days of your billing, I will become personally responsible for the amount. I will have thirty days to clear that account. If the account is not cleared in thirty days, I hereby authorize you to collect any outstanding amount on my credit card listed below.**
2. **Any insurance checks that may be forwarded to me for services received at Phoenix Therapy and Rehabilitation, Inc. and/or Family Wellness Center, Inc. and not paid for, will be endorsed by me and turned over to Phoenix Therapy and Rehabilitation, Inc. and/or Family Wellness Center, Inc. within five working days of receipt, for payment on my account. If I do not clear this portion of my account within five days, I hereby authorize you to collect the full amount of my account on the credit card listed below.**
3. **Any balance that is on my account will be paid for and cleared within 30 days of notification of amount. If a balance remains within thirty days, I hereby authorize you to collect that amount in full on the credit card listed below.**
4. **Disclosure Of Financial Interest**
    a. **This notice is to inform you, in accordance with Florida law, that Dr. David Livingston has a financial interest in the entities listed below:**
    Phoenix Therapy and Rehabilitation Services, Inc. d/b/a Advanced Therapy Center of Delray Beach15127 Jog Road, Suite 210, Delray, Florida 33446
    Family Wellness Center, Inc. 15127 Jog Road, Suite 210, Delray, Florida 33446
    You are under no obligation to utilize the facilities referenced above and whether or not you do will have no impact on either the decision of Dr. Livingston to provide you with health care services at this facility, or on the treatment you receive.
    You may consult your primary care physician or other individuals regarding your choice of provider, as you have the right to obtain health care services from the entities listed above or another one of your choice. A list of alternative local facilities is provided below: FYZICAL Therapy and Balance, 7431 W Atlantic Ave, Delray Beach, FL 33446 James Incledon, D.C. 6609 Woolbright Road, Suite 414, Boynton Beach, FL 33437

Name on Card_____
Credit Card Type MasterCard Visa AMEX
Card Number_____
Expiration Date___/___/_____
Signature for 1-4 above_____
Witness Signature_____
Witness Name_____