OUTPATIENT TREATMENT FINANCIAL AGREEMENT

This Agreement is entered into this ________ day of ________________, 20____ by and between ___The Suites Rio Vista_______ hereinafter referred to as “facility” and ____________________________________, hereinafter referred to as Responsible Party/Patient.

FACILITY RESPONSIBILITIES

1. The facility shall provide services and materials, as described in Section 2 below, in compliance with the orders of the Patient’s physician. Administration of medicines and treatments shall be ordered by the Patient’s physician.
2. Facility shall provide the following prescribed services to Patient (circle all that apply)

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   Additional services may be provided by facility upon receipt of subsequent orders from the Patient’s physician. Any such services provided by facility shall be subject to all the terms of, conditions and obligations of this Agreement.
3. Facility welcomes all persons without regard to race, color, national origin, religion, sex, or qualified handicaps.

PATIENT/RESPONSIBLE PARTY RESPONSIBILITIES

1. Patient and Responsible Party agree jointly and severally to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient for the services described herein and to pay such charges as they become due.
2. Patient and Responsible Party further agree that, if any of the services rendered by facility to Patient, are covered by insurance, or benefits under either Title XVIII or Tile XIX of the Social Security Act (Medicare/Medicaid), it is nevertheless the joint and several obligation of Patient and Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Responsible Party further agree that any co-insurance or deductible obligation under Medicare, Medicaid or private insurance must be paid directly to facility by Patient and Responsible Party.
3. Patient and Responsible Party further agree that any charges which are not made IN FULL when due shall be subject to a late charge of ten (10%) percent per annum until paid.

PATIENT'S CERTIFICATION

1. Patient certifies and warrants that all information submitted on behalf of Patient for purposes of applying for or receiving benefits under Title XVIII or XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Responsible Party warrants that all information they have supplied to facility is correct and true and further agree to hold harmless and indemnify facility from and against any and all loss, damage, cost, expenses, or liability resulting from Patient’s or Responsible Party's submission of false or incorrect information to facility
2. Patient authorizes any health care facility or doctor to furnish the facility and/or or the Social Security Administration, its fiscal intermediary or carrier all requested information from Patient's medical or financial records. Patient further authorizes facility to disclose all or any part to Patient’s medical or financial records to any person or entity which is or may be liable under contract to facility to Patient or to a family member or to the employer of Patient to pay all or a portion of the costs or care provided to Patient including, but not limited to, hospital or medical service companies, insurance companies, worker’s compensation carrier, welfare fund of Patient’s employer. Patient further authorizes facility to disclose all or any part of Patient’s medical or financial records to any independent auditor of facility.
3. Patient requests and hereby authorizes that payment for any authorized benefits be made directly to facility on Patients behalf.
4. Facility does not make any assurance of any kind whatsoever that Patient’s care will or can be covered by Medicare/Medicaid or any private insurance, and the Patient and Responsible Party hereby release facility, its agents, servants, and employees from any liability or responsibility in connection with the Patient’s and/or Responsible Party's potential claim of coverage under Medicare/Medicaid and/or private insurance program.

RESTRICTIONS AND LIABILITIES

1. Patient and Responsible Party hereby release facility from any and all harm, liability, injury or loss suffered by Patent while outside the physical confines of facility and/or the supervision and contract of facility staff.
2. Facility shall have no liability for injuries of any kind suffered by Patient while under its care, except where the injury is caused by the negligence of facility or its regular staff, or as required by law. If Patient discontinues or suspends treatment before the attending physician has so ordered, or if Patient fails to follow a prescribed regimen of activity, treatment or therapy, Patient and Responsible Party agree to assume all responsibility for any result which may follow Patient's action.
3. Facility is not responsible or liable for any injury to Patient caused by facility visitors attempting to assist to treat Patient in anyway. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted into patient treatment areas of the facility.
4. Facility is not liable or responsible for any personal belongings brought into and left at facility by Patient, except as required by law.

MISCELLANEOUS

1. Where Patient is eligible for Medicaid benefits and/or where facility is precluded under state or federal law in requiring that a Responsible Party act as guarantor for Patient, the term "Responsible Party", as used herein, shaft be deemed to mean “Patient Agent”. The Patient Agent is responsible for assuring that any of Patient’s own funds, over which such Patient Agent exercises any

management or control, and which constitutes the Patient's share of costs or liability to facility, shall be paid to facility as such liability is incurred.

PATIENT AND RESPONSIBLE PARTY HEREBY CERTIFY THAT EACH HAS READ THIS AGREEMENT IN ITS ENTIRETY, UNDERSTAND AND AGREE TO ITS TERMS AND CONDITIONS. RESPONSIBLE PARTY, OR OTHER PERSON WHO SIGNS THIS AGREEMENT ON BEHALF OF AND IN THE PLACE OF THE PATIENT REPRESENTS THAT HE/SHE IS AUTHORIZED BY PATIENT TO DO SO, AND THE ABOVE NAMED PATIENT AND EACH RESPONSIBLE PARTY SIGNING THIS AGREEMENT AGREES BY SO SIGNING ACCEPTING ALL OF THE TERMS HEREOF AND TO PERFORM ALL OBLIGATIONS HEREUNDER. THERE ARE NO REPRESENTATIONS MADE BY FACILITY OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAN ARE SET FORTH IN THIS AGREEMENT.

____	______________________________
Patient (or Legal Guardian)	Date
____	______________________________
Responsible Party	Date
____	______________________________
Facility Representative	Date
____	______________________________
Witness (if patient or legal guardian cannot sign)	Date