**B&B Physical Therapy  
6415 N Monroe St  
Spokane, WA 99208**

\*This is an agreement between B&B Physical Therapy, a Washington Professional Corporation as creditor, and the Patient/Debtor named on this form.   
\*In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor.  
The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to B&B Physical Therapy.   
\*By executing this agreement, you are agreeing to pay for all services that are received.   
**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show the current balance due, and the finance charge, if any.   
**Payment Options: Cash, Check, Visa, Mastercard.   
Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.   
**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.   
**Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.   
**Non-Contracted Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.   
**Finance Charge:** A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum **FINANCE CHARGE** is $0.50.   
**Required Payments**: Any co-payments required by an insurance company must be paid at the time of service.   
**Returned Checks:** There is a fee (currently $25) for any checks returned by the bank.   
**Missed Appointment Fee:** Patients who do not show up for an appointment, or cancel with less than 24 hours notice will be charged a $20 fee. This fee must be paid before a new appointment is scheduled. Patients with three (3) or two (2) no-call/no-show appointments will be asked to schedule the day of appointment.

**Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers’ fees which we incur plus all court costs.   
**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party   
(If NOT the Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_