

This agreement is entered into by and between:

Patient Name: **and ("Patient") and Salerno Wellness ("Practice").**

Purpose of the Agreement

The purpose of this agreement is to establish clear responsibilities regarding the handling of insurance payments and Explanation of Benefits (EOBs) for services provided by the Practice, which operates as an out-of-network provider for the Patient's insurance plan.

Acknowledgment of Responsibility

By signing this agreement, the Patient acknowledges and agrees to the following:

1. Insurance Payments and EOBs:

- The Patient understands that their insurance company may issue payment directly to them for claims submitted by the Practice.
- The EOB accompanying such payments will indicate that the Patient is responsible for paying the outstanding balance to the Practice for the services rendered.

2. Obligation to Remit Payments:

- The Patient agrees to promptly forward any insurance payments and associated EOBs to the Practice upon receipt.
- Payments must be rendered to the Practice within 7 business days of the Patient receiving them.

3. Non-Compliance:

In the event that the patient fails to remit payment to the practice as required, the following actions may be taken:

- **Referral to Collections:** If payment is not received within a specified period, the account may be referred to a third-party collections agency for further action. The patient will be responsible for any additional costs incurred during the collections process, including but not limited to collection fees, court costs, and attorney fees.
- **Legal Action:** In the event of continued non-payment, the practice reserves the right to pursue legal action, including filing a civil lawsuit to recover the outstanding balance. The patient will be responsible for any costs associated with such legal actions.
- **Insurance Fraud Reporting:** If evidence suggests that the patient has intentionally misrepresented information or engaged in fraudulent activity regarding insurance claims (such as cashing checks intended for payment to the practice), the practice may report the incident to law enforcement authorities for investigation of potential criminal charges.
- **Suspension of Services:** The practice may, at its discretion, suspend or deny further medical services until the outstanding balance is paid in full.

The patient understands and agrees that failure to comply with the agreed-upon payment terms may result in the actions outlined above, which could affect the patient's credit and future access to medical care.

4. Direct Payment Authorization:

- The Patient agrees to cooperate with the Practice to request that their insurance company issue payments directly to the Practice for any future claims.

5. Use of Insurance Payments:

- The Patient acknowledges that funds issued by the insurance company for services rendered by the Practice are intended solely to cover their medical bills. These funds must not be used for any other purpose.

Authorization and Consent

By signing below, the Patient agrees to the terms outlined in this agreement and acknowledges their financial responsibility to the Practice.

PATIENT'S SIGNATURE

DATE

PRACTICE REPRESENTATIVE SIGNATURE:

DATE

----------------------	----------------------	----------------------	----------------------

Important Notice to Patients

If you have any questions about your insurance payments or this agreement, please contact our office at 212-582-1700. We are here to help you navigate the process and ensure clarity regarding your financial obligations.

This agreement is binding and enforceable under applicable state laws.