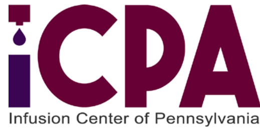

ICPA Financial Agreement

Patient Name:		Date of Birth:	

The information below is required **only** if the person executing this agreement is **not** the Patient

Full Name:				Relationship to Patient:	
Street (Line 1):				Social Security Number:	
Street (Line 2):				Home Phone:	
City:				Cell Phone:	
State:		Zip:		Work Phone:	

By my signature below, I agree as follows:

1. **ICPA Has Prepaid the Cost of Drugs**

   I understand that the Patient named above ("Patient") is about to begin infusion therapy provided by the Infusion Center of Pennsylvania, LLC ("ICPA").

   I understand that greatest contributor to the total cost of this therapy is the cost of the drug(s) to be infused. I understand that, depending on the prescription, these drug(s) may cost thousands or even tens of thousands of dollars per dose.

   I understand that ICPA has prepaid these costs on the Patient's behalf, with the expectation that it will be compensated by the Patient's insurance or other third parties (collectively "Payors"), or ultimately by me.

2. **Good Faith Estimate**

   I have received a copy of the **ICPA Benefits Estimate** for the cost of treating the Patient. I understand that the estimate of the amounts that Payors will pay were made in good faith, solely as a convenience to me, based on what those Payors told ICPA.

   I acknowledge that the actual amounts Payors ultimately pay may differ significantly from the estimate I have been provided, and that my cost may therefore be different. I agree that ICPA has no control over the amount that Payors ultimately pay.

I agree that it is my responsibility to verify ICPA's estimates to my own satisfaction prior to beginning each infusion the Patient receives, and I agree not to hold ICPA responsible if the actual cost of treatment is different from the estimate provided for any reason, including estimation errors by ICPA staff.

I understand that the cost of treatment may also differ from the ICPA's initial estimate if there are changes or additions to the care initially prescribed.

3. Agreement to Pay

I agree to be responsible for the full payment of all charges to which the Infusion Center of Pennsylvania, LLC ("ICPA") is entitled for medical treatment of the Patient named above, even if this amount differs significantly from the estimate I have received.

In making this Agreement, I understand that I may be responsible for various charges, including but not limited to co-payments each time the Patient visits ICPA for treatment, an insurance deductible which must be satisfied before insurance benefits begin, and co-insurance, the portion of each bill that insurance does not pay.

4. Payment Due Dates, Agreement to Assist

If the Patient's insurance requires co-payments, I agree to make them at the time of each office visit. I further agree to pay any estimated deductible(s) within 30 days of each office visit. The deductible amount due may be up to the Patient's total remaining deductible(s) for the year (or the total amount of the bill if it is less).

After these payments, I understand that ICPA will attempt to collect the remaining balance on the Patient's account from all Payors. I agree to assist ICPA's collection efforts in any reasonable manner that ICPA requests, including by contacting the Payor, regulatory authorities, or others by phone, in writing, or by submitting documentation, affidavits, testimony or other evidence, for as long as ICPA deems necessary. However, I agree that my assistance in this regard does not absolve me of the obligation to pay set forth in Paragraph 5, below.

5. Remaining Balances Due

I understand that after ICPA, in its sole judgement, has collected the maximum benefit amount possible from all Payors for each treatment, I will receive an invoice for the remaining balance. The invoice may include unpaid deductibles, co-payments, co-insurance, and other charges that insurance has denied and that ICPA is contractually permitted to bill.

I agree that I will pay the entire invoiced amount within 30 days.

I understand that the Patient and I may continue to try to collect additional sums from insurance and other third-party Payors after ICPA's invoice has been settled. ICPA will comply with reasonable requests for assistance, but I agree that after ICPA has invoiced me, responsibility for continued collection efforts will be my own.

Any Payor payments received by ICPA after the Patient's account has been settled will be reimbursed to me, pursuant to the Assignment of Benefits clause in the **ICPA Patient Agreement**, which I agree to incorporate into this ICPA Financial Agreement by reference.

6. Overdue Balances

I acknowledge that subsequent treatments may be delayed or denied because of overdue balances or unpaid patient obligations. I also acknowledge that ICPA may place liens and take other actions to collect overdue or unpaid invoices. I agree that in addition to the balance(s) due, I will be liable for the cost of any collection efforts plus an additional 1.5% monthly finance charge on any unpaid patient obligations outstanding for 90 days or more.

7. Assignment of Benefits

I understand that ICPA will bill insurers directly for the costs of the Patient's treatment, including, in most cases, the cost of the drugs administered. I hereby assign to ICPA any insurance or other third-party payments received (whether by insurance carriers, co-pay assistance programs, charitable foundations, or any other entity or individual).

If any Payor does not accept the "assignment of benefits" described above, or if payments are sent directly to me for any other reason, I agree to immediately remit these payments in full to ICPA.

I understand that any payments received by ICPA after the balance on my account has been settled will be reimbursed to me within 30 days of receipt.

8. Patient Responsibilities

I agree that it is the Patient's and my responsibility to submit complete and accurate information to ICPA, and to keep ICPA informed of any changes to the Patient's insurance coverage. When ICPA and I agree to participate in co-pay assistance or other third-party assistance programs, I acknowledge that it is the Patient's and my responsibility to register for such programs and complete all required documentation.

9. DME

If ICPA provides any "durable medical equipment" (DME) such as an infusion pump for the Patient to take home, I agree to pay for any loss or damage beyond normal wear and tear, along with applicable equipment rental charges.

I have read and understand this entire ICPA Financial Agreement and consent to its terms.

x____________________________________ ____________
Signature Date Signed

____________________________________ ______________________
Print Name Relationship to Patient