

Patient Financial Responsibility Agreement

1. Self-Pay & Non-Insurance Acknowledgment

Physioregenix provides regenerative and orthobiologic treatments that are generally not covered by commercial insurance, Medicare, or Medicaid.

I understand that:

- My treatment is considered elective and self-pay.
- Physioregenix does not bill insurance on my behalf.
- I am financially responsible for all services rendered.
- Payment is due prior to treatment unless otherwise agreed in writing.

Patient Initials: _____

2. Payment Methods Accepted

Physioregenix accepts:

- Major credit cards (Visa, MasterCard, American Express, Discover)
- CareCredit financing
- Debit cards
- HSA / FSA cards (if applicable)

Cash and checks are not accepted.

3. CareCredit Financing

If I elect to use CareCredit:

- I understand CareCredit is a third-party financing company.
- Approval is determined solely by CareCredit.
- I am responsible for complying with CareCredit repayment terms.
- Any promotional financing terms (e.g., deferred interest) are between me and CareCredit.
- Physioregenix is not responsible for CareCredit interest charges or penalties.

If CareCredit payment is declined or reversed, I remain personally responsible for the full balance.

Patient Initials: _____

4. Treatment Fees & Packages

I understand that:

- Treatment fees are quoted prior to the procedure.
- Multi-treatment packages must be paid in full prior to the first procedure unless otherwise agreed.
- Package pricing reflects a discounted rate.

Unused treatments from a package are:

- Non-refundable any third party purchase that has already been made
- Refundable at the clinic's discretion minus services already rendered at full individual rates.

5. No Guarantee of Outcome

I understand that regenerative medicine treatments:

- Do not guarantee symptom relief
- May not eliminate the need for surgery
- May require additional treatment
- Vary based on individual healing response

Payment is for the procedure performed, not for a guaranteed outcome.

Patient Initials: _____

6. Imaging & Diagnostic Requirements

I understand that:

- Updated imaging may be required prior to treatment.
- If imaging is incomplete or outdated, additional costs may be incurred.
- If I decline recommended imaging, treatment may be postponed or canceled.

7. Cancellation & No-Show Policy

Because regenerative procedures require preparation time and sterile supplies:

- Cancellations less than 48 hours notice may result in forfeiture of rescheduling privileges
- No-shows may forfeit deposit or incur a fee.
- Deposits are non-refundable within 48 hours of scheduled procedure.

8. Refund Policy

I understand that:

- Refunds are not issued once a procedure has been performed.
- Supplies prepared specifically for my procedure are non-refundable.
- Chargebacks filed after services are rendered may be disputed by Physioregenix with documentation.

9. Outstanding Balances

Unpaid balances may be:

- Subject to collection efforts
- Subject to reasonable administrative or collection fees
- Reported to credit agencies where permitted by law

10. Authorization to Charge Card

By signing below, I authorize Physioregenix to:

- Charge my credit/debit/HSA/FSA card for agreed-upon services
- Charge cancellation or no-show fees consistent with this policy

11. Acknowledgment

I have read and understand this Financial Responsibility Agreement. I have had the opportunity to ask questions. I agree to comply with the policies outlined above.

Patient Name (Print): _____

Signature: _____

Date: _____

Clinic Representative: _____

Date: _____