

UNINSURED PATIENT PROVIDER AGREEMENT

This Provider Agreement (“Agreement”) is made and entered into by and between the uninsured patient signing below (hereinafter “patient”) and H/S Therapy Associates, Inc. (hereinafter “Provider”).

By signing below, the patient acknowledges qualification for this agreement by either not having medical insurance or by being insured by a medical insurance carrier that has: (1) a specified benefit limit for outpatient physical therapy care that the patient has exhausted; or (2) a capitation requirement (or similar restriction) for outpatient physical therapy care that would prohibit the patient from receiving care in this clinic under the insurance plan.

The Effective Date of this Agreement shall be the earlier of: (a) the patient’s first date of service in this clinic for which the patient was not covered by a medical insurance plan; or (b) the date that this Agreement was executed by the Patient and Provider.

Patient and Provider mutually agree to enter into an agreement whereby Provider will provide outpatient physical therapy services to the Patient with the objective of delivering cost-effective quality health care services to uninsured patients or patients who have medical insurance but the coverage under the policy prohibits receiving outpatient physical therapy care by Provider (as noted above).

Covered Services: Outpatient physical therapy services provided by Provider.

Non-Covered Services: Supplies recommended by Provider that the patient may choose to purchase. Post-Discharge Fitness Program fees. MAXLIFE Health Center Fees.

Compensation Rates: Provider shall accept as payment in full for Covered Services rendered under this Agreement to the Patient an amount equal to 70% of the Provider’s current Schedule of Fees (attached hereto).

Payment: Payment for provided services shall be payable at the time the service is rendered.

Term of Contract: The term of this Agreement shall commence on the Effective Date and shall continue until the patient’s last service date or until the patient no longer qualifies for an uninsured patient status whichever shall occur earlier.

EXECUTION PAGE

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on the date as determined above.

PATIENT

PROVIDER

Patient Signature

Provider Signature

Printed Name

Printed Name

Date

Date