Workers's Compensation Agreement of Financial Responsibility with Angela Ferri, Principal

Thank you for choosing me as one of your health care providers. I am committed to providing quality care and service to my patients. The following is a statement of my financial policy, which I require that you read and agree to prior to our working together.

• Please understand that payment of your bill is considered part of our treatment agreement. Fees are payable when services are rendered. I accept cash, check, Venmo and Zelle, and pre-approved Workers Compensation for which I am a contracted provider.

• It is your responsibility to know your own worker's compensation benefits, including whether I am a contracted provider with your workers compensation payer, your covered benefits and any exclusions in your benefits, and any pre-authorization requirements of your workers compensation payer.

• I will attempt to confirm your workers compensation coverage prior to your treatments. It is your responsibility to provide current and accurate referral information, including any updates or changes in coverage. If I am not provided this information, you will be financially responsible for denied claims.

• If I have a contract with your workers compensation payer (from here forward referred to as "payer"), I will bill your payer first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the payer.

• If I do not contract with your payer, you will be expected to pay for all services rendered at the end of your visit. I will provide you with a statement that you can submit to your payer for reimbursement.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my workers compensation payer denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party Date

Name of Patient/Responsible Party (please print) Relationship to Patient

09-2025