FINANCIAL RESPONSIBILITY AGREEMENT AND AUTHORIZATION TO TREAT

By signing below, I understand and agree that:

- Swiss Balance Inc. agrees to provide prosthetic/orthotic/pedorthic device(s) and/or service(s) to me as prescribed by my physician(s).
- I consent to the prescribed treatment and am ultimately responsible for the balance of my account for any professional services rendered and prosthetic/ orthotic/pedorthic products provided regardless of my insurance status.
- All information and documentation provided to Swiss Balance Inc. is true and accurate to the best of my knowledge.
- If no device(s) is purchased and/or off-the-shelf product(s) is returned, an evaluation fee of $85.00 applies.
- To comply with California law, I acknowledge that custom-made prosthetic/orthotic/ pedorthic appliances are NON-REFUNDABLE.
- In the event that I do not make payment as demanded, I agree to pay a monthly finance charge of 1.5% of the outstanding unpaid balance.
- In the event that legal action is required by Swiss Balance Inc. to enforce my obligation for the charges, I will bear full responsibility for all the reasonable attorney fees, court costs and other collection expenses associated with enforcement of the charges incurred.

NOTICE OF PRIVACY PRACTICES

Upon my request, Swiss Balance will provide me with a copy of the Notice of Privacy Practices. This document describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Swiss Balance Inc.'s health care operations. It also describes my rights and Swiss Balance Inc.'s duty with respect to my protected health information. Swiss Balance Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by requesting a copy to be sent by mail or asking for one at the time of my next appointment. I authorize Swiss Balance Inc. to release any required documentation for legal purposes applicable by law.

Date: _____ / _____ / _____
Month Day Year

Signature ______________________________________
(If the patient is a minor, parent or legal guardian must sign)

Print Name ______________________________________