LONGEVITY REHAB CENTER, INC.

PATIENT FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care If you have insurance, we will gladly accept assignment of benefits and file all insurance claims provided verification of your insurance policies allows assigned benefits and coverage for the services rendered.

Please read the following statements carefully. By signing below, you agree that you have read and fully understand all statements contained herein.

I, the undersigned, understand the Longevity Rehab Center, Inc. will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make payment for services rendered, I am fully responsible for all charges incurred, and will pay in full for all services. I understand that I am responsible for payment of any and all deductibles and/or CO-insurance amounts or if payment is sent directly to me, and the charges incurred are not subject to any fee schedule or reduction make by my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payment of the fees are not contingent upon settlement of a litigation; however, I hereby instruct my attorney to pay Longevity Rehab Center, Inc. in full, direct form the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS: Accepting assignment means that the provider of services agrees to accept the "allowable charges" as determined by Medicare as full payment. However, Medicare pays 80% of the "allowable charge". Therefore, you are responsible for the 20% balance. In addition to the 20%, you are also responsible for any amounts toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT: Longevity Rehab Center, Inc. has explained to me that under Medicare guidelines, I will be responsible for 20% of the allowable charge. As Longevity Rehab Center, Inc. has agreed to accept assignment of benefits on this portion of the charges also, I understand that should the supplemental insurance company fail to pay for these charges within "a reasonable length of time", or send payment directly to me, I will become responsible for payment in full.

WORKER'S COMPENSATION COVERAGE: Longevity Rehab Center, Inc.. agrees to treat and bill worker's compensation for preauthorized work related injuries per the Worker's Compensation Guidelines for the State of Florida. However, if for any reason Worker's Compensation denies liability for the treatment of the injury I understand I become responsible for full payment of the charges.

NOTICE OF THE USE AND DISCLOSERS OF PROTECTED HEALTH INFORMATION

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present, or future physical or mental health condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information we maintain that about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose you're Protected Health Information to another physician, such as specialist, to whom we refer you for medical treatment.
2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyses our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for the purposes of their health care operations.
3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) Disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determine whether the amount we charge you for medical services are justifiable. (e) Disclosures to determine whether the amount we charge you for medical services are justifiable.
4. Reminders and Treatment Alternatives: We may contact you and provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your Protected Health Information use or disclose your Protected Health Information in connection with treatment, payment, or health care operations if we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatments situations, to carry out treatment, payment or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activates, such as controlling communicable disease, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA- related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such overseeing government benefit programs; (d) in response to judicial or administrative

orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; (h) for selected governmental functions, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke your authorization. You have the right to revoke your authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.
2. The right to request in writing and receive confidential communications of your Protected Health Information by alternative means (such as by mail or email) or at alternative locations (such as your office or business workplace).
3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in case where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.
4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.
5. The right to receive an accounting of all our disclosers of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.
6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Paul St Mary, Director Of Operations. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules (c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless the time limit is waved by the DHHS for good cause shown. The complaint may be sent to Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza , Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Paul St Mary at 772-978-9750.