OUTPATIENT FINANCIAL AGREEMENT

Patient Name: _____ Date: _____

Responsible Party Name: _____ RP SSN: _____

I understand that I will be responsible for payment for the services provided to me or my dependents from Family Care Center (FCC), and that my portion of the charges are to be paid at the **TIME OF SERVICE**.

☐ **INSURANCE / THIRD PARTY**: I authorize the insurance reimbursement under my policy(s) with TRICARE, or any other insurance or third-party coverage which I might be authorized for, be made on my behalf to FCC. Based on my insurance policy, my outpatient co-pay is determined by my insurance company. It is my responsibility to understand the benefits provided by my insurance company(s) and to contact them to determine what my co-pay, co-insurance, or deductible is.

- If the services you receive are covered by your plan: All applicable co-pays co-insurance and deductibles are requested at the time of the office visit.
- If the services you receive are not covered by the plan or your insurance has lapsed: Payment in full of the self-pay rate is requested at the time of the visit.

It is your responsibility to keep your insurance information up to date with our clinic in order for the claims to process correctly. I understand that I will be responsible for the full amount if I fail to take the necessary steps to obtain insurance payment for FCC. I hereby authorize FCC to submit claims on my behalf to my insurance company(s) or third party carrier for all services that I or my dependent(s) receive from FCC. FCC has agreed to accept payment from your insurance company at a contracted rate, which may be below our usual and customary charge.

☐ **SELF-PAY**: I am prepared to pay full fee for all services provided to me or any of my dependents by FCC at the time of service. I will be charged the self-pay rates as quoted at the time of service. This applies also when we have been told you do not have Medicaid and it comes out later that you do. We are not a Medicaid provider and cannot treat you as a self-pay patient if you have Medicaid.

PAYMENT PLANS

Should you be unable to pay your portion of the charges or accumulate a bill greater than $100, we will not be able to schedule you for any further appointments unless you agree to a payment plan by placing a credit card on file. We will charge your card your $50 a month until the debt is paid off.

RECORDS REQUESTS

Generally, for behavioral health records, only a summary of care is provided. Records requested by a medical facility for continuity of care will be sent at no cost. All others requesting records to include the patient are charged a fee of $25 for a Treatment Summary, Health Records in their entirety $15.00 plus .25 per page. All health record fees are collected prior to the release of the records. Requests must be cleared by the provider, so please allow 15 business days to process records requests. If you would like to put a rush on your records request at a '3-business' day return the fee is an (additional) $50.00.

PAYMENT

Payment in full is required at the time of service. No further services will be scheduled if your account is behind. Co-payments are due at the time of service or you will be rescheduled. Patients who return for treatment following an unsatisfactory payment history may be referred to other providers for services.

CONSULTATION

Consultation telephone calls longer than 5 minutes in connection with legal actions are billed at the rate of $100.00 per hour with a minimum of 1 hour. Court appearances are billed at $250 an hour with a minimum of 3 hours. **Please note**, we do not do assessments or evaluations for the purpose of legal commitment, residential treatment, establishing parental rights or child custody and we cannot render opinions for these matters.

PATIENTS UNDER THE AGE OF 15

The parent or legal guardian of a child under the age of 15 must sign all documents and agreements. The parent who initially brings the child for behavioral health care at FCC is primarily responsible with communication and coordination with the other parent / guardian.

***** In cases of divorce or separation, the parent who originally brought the child in for services, and who is signing this document, is responsible for paying for services regardless of which parent might be legally responsible for insurance coverage or medical bills as established by divorce or other agreement.

I have read and understand the above billing policy. I agree to pay for services under the conditions and specifications set forth in this billing policy and acknowledge that i am responsible for payment of all services provided, regardless of insurance coverage, and including collections or court costs should that process become necessary in settlement of my account.

I hereby authorize the release of any information necessary to process my claim to my insurance company or other third-party payer identified below. I understand that this may include mental health diagnosis and treatment information, including information about drug or alcohol abuse and HIV conditions. It may also include the release of information for the determination of eligibility or coverage and adjudication or subrogation of health benefit claims; it may include billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; it may include a third party payers review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; it may include a third party payer's utilization review activities, including pre-certification and pre-authorization of services, as well as concurrent and retrospective review of services; and it may include disclosure to consumer reporting agencies of any of protected health information relating to collection of payments or reimbursement. I understand that this authorization to release information is valid for one year, and I may revoke it at any time by written request, except to the extent that FCC has already acted in reliance thereon, including the provision of treatment services in reliance on a valid consent to disclose information to a third-party payer.

The release/authorization is valid for one year unless indicated otherwise here: _____
Date to Stop Consent

Patient Name (Print) _____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Family Care Center
1330 Quail Lake Loop, Suite 260
Colorado Springs, CO 80906

I hereby REVOKE this Consent to Release/Authorization for Information			
	/ /		/ /
Patient Signature of	Date	Witness	Date