Bear's Ears Child & Family Therapy
Hearing & Healing

RESPONSIBLE PARTY FINANCIAL AGREEMENT

(To be completed if patient is 18 years of age or older and another party is assuming financial responsibility.)

Patient Name Last: _____ First: _____ Middle: _____

Responsible Party Name Last: _____ First: _____ Middle: _____

You are responsible to pay for all services provided to the above name patient by Bear's Ears Child & Family Therapy. If the patient's insurance company does not pay charges, you must pay them.

HOW AND WHEN YOU PAY

Payments are always due prior to services being rendered. If you will not be with the patient at time of service, arrangements must be made to pay for services in advance. All charges for services not covered by insurance must be paid as soon as such charges are calculated. If you do not make payment (whether co-payments or other amounts) the patient's appointment may be rescheduled. You can pay in cash or with MasterCard, Visa, Discover and American Express. Checks will be accepted only with management approval. A $25.00 service charge will be assessed for any checks returned by the bank for insufficient funds.

INSURANCE

If the patient has insurance, we will be happy to bill the insurance company as a courtesy. You must still pay the required co-payment at or before the time of service, as well as any deductible and/or percentage not covered by insurance.
We will try to answer any questions relating to insurance and will help the patient obtain from their insurance company any estimates for coverage. Please realize that:

1. Insurance is a contract between the patient, the insurance company and often the patient's employer. We are not a party to that contract.
2. Not all services rendered are covered benefits in all insurance contracts. Some insurance companies select certain services they will not cover.

YOU MAY HAVE TO PAY FOR MISSED APPOINTMENTS

Appointments are time we reserve for the patient. If a patient is unable to keep their appointment, we ask that the patient gives us the courtesy of at least 24-hour notice. This will allow us to schedule other patients who are waiting for an appointment. In the event the patient misses an appointment without a minimum of 24 hours advance notice, you agree to pay a $50.00/hour missed appointment fee. Chronic cancellations and no-shows for scheduled appointments may require payment in advance to reschedule.

COLLECTIONS

Collection activity will be pursued when a balance is more than 60 days old and several attempts have been made to collect payment. Any collection fees incurred will be assessed for every account turned over to collection. If the patient's account is in collection, all future appointments will be cancelled and no further appointments will be made until the account is paid in full.

FINANCIAL RESPONSIBILITY

I understand the above policies and agree that I am responsible for the payment of all fees on the patient account. I understand that payment is due at time of service. I understand that failure to pay the balance due may result in this account being referred to an attorney or collection agency and that I will be responsible for paying any costs of collection including attorney fees.

_____ _____

Responsible Party Signature Date