LIVING HOPE CLINIC

EXPLANATION OF FINANCIAL POLICY

You are responsible for the timely payment of your account. The following is our detailed payment policy:

1. Although insurance will usually pay for a portion of these services, it is a contract between you and your insurance company. We are **not** a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exits.) However, we do not feel it appropriate to become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.
2. Therefore, payment is expected at the end of each session unless other arrangements are made. The full fee will be required at the end of the first session. (We file insurance claims as a courtesy to you if your treatment exceeds one hundred dollars ($100.00). After that, the insurance deductible amount needs to be paid until it is exhausted. When or if there is no deductible, the co-payment is required. If the co-payment cannot be verified, it will be assumed that it is fifty percent (50%) of the usual and customary charge. This is because ninety percent of local insurance companies require a fifty percent (50%) co-pay. If your insurance company pays more than the balance due, we will send a refund check to you immediately.
3. Since you will be paying at time of service, your account should never be in arrears, but if regular payments for outstanding balances are not made monthly, interest will be charged. A Service Charge of 1.5% per month will be added to those accounts remaining unpaid after 30 days. This is an annual percentage rate of 18%.
4. If for some reason no payments are made on your bill **by you** for a period of 60 days, it will be turned over to our collection agency. An additional charge of 33 and 1/3 percent will be made for this service. If payments still are not made, they will take the matter to small claims court. Costs for this service will be added to our bill.
5. Fifteen dollars will be charged for all returned checks.
6. When you are given an appointment, you are expected to keep it. Twenty-four hour notice is required if you cannot keep your scheduled appointment. If failure to appear for an appointment occurs without 24-hour notice, or without good cause, a minimum charge of $50.00 will be charged. No further treatment will be given until this charge is paid.
7. Patients will be discharged from this office after a second broken appointment.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

Responsible Party Signature_____ **Date**_____

Witnessed By _____ **Date**_____

LIVING HOPE CLINIC
CONSENT FOR TREATMENT

I consent to receive services from Living Hope Clinic. I understand that my participation in the program includes appointments with Mental Health Professionals. Developmental Disability Professionals. and/or Substance Abuse Professionals and consideration of treatment options that may be recommended. I consent to participate in the assessment of my need for specific treatment services that may be available. I agree to participate in the development of a treatment plan and to participate in specific treatment services and activities as arranged in that plan.

I understand that I have the right to be informed about specific services and procedures. including information about risks. benefits and alternatives to each service proposed for my treatment.

I understand I have the right to refuse or discontinue any service or procedure. In cases where treatment has been ordered by a court. I may still refuse to participate in recommended treatment. however. there may be legal consequences from failure to follow the recommended treatment.

I understand that in the event that I fail to keep appointments and have not received services for 90 days. the episode of care will be discontinued.

I understand that there will be charges for services that I am provided. If I have insurance that can be billed. this will be handled by Living Hope Clinic. If I have no insurance coverage. fees will be charged directly to me based on a sliding fee scale that verified income and family size.

I understand that all the individuals participating in treatment are expected to conduct themselves in an appropriate and respectful manner and to follow established program rules. Any aggressive. violent. threatening. or illegal behavior will be the basis for my exclusion from service.

I acknowledge that I was provided with Living Hope Clinic's Notice of Privacy Practices.

I understand and agree to Living Hope Clinic's policy and procedure that no firearms are to be allowed on the premise at any time. Should any participate or individual choose not to abide by this policy. I understand that 911 will be called immediately and that individual will be escorted from the premises.

I understand that this consent for services is effective for the duration of my treatment at Living Hope Clinic unless expressly revoked. My signature below indicates my understanding and agreement to the information above.

Patient Signature_____ Date:_____

Witness:_____ Date:_____

LIVING HOPE CLINIC

ASSIGNMENT OF BENEFITS

Patient: _____

I AUTHORIZE payment of medical benefits be paid directly to the undersigned doctor or supplier for services rendered, or any benefits payable from another entity payable to me (insured), but not to exceed the balance due of the doctor's regular charges for the period of treatment rendered which is covered by the enclosed claim.

I AUTHORIZE the release of any medical information necessary to process the claim and request payment of MEDICARE benefits either to me or to the party who accepts assignment below.

I UNDERSTAND my insurance will be billed as a courtesy to me. If my insurance does not pay within 90 days of being billed, I shall be responsible for payment of the total balance due.

A copy of this authorization shall have the same force and effect as the original.

Doctor _____ Counselor _____

_____ _____

Signature of Guarantor/Insured Date

_____ _____

Witness Date