FINANCIAL POLICY AGREEMENT

Client Name: _____ Date: _____

Please initial your payment selection/s and complete payment information and back of form.
A copy of your photo ID will be needed for identity verification.

☐ I will not be using insurance and agree to pay $205 for the first session and $165 for subsequent sessions.

☐ I will be using Medicare benefits to pay for my counseling and my counselor is a Medicare provider.

- ✓ I understand I am financially responsible for all treatment that Medicare or other insurance does not pay for.
- ✓ ☐ I will be using a secondary insurance. Carrier: _____

☐ I have Medicare but will NOT be using Medicare benefits to pay for my counseling.

- ✓ I understand that my counselor does not accept Medicare reimbursements and have discussed this and signed necessary forms (ABN).

☐ I require a fee subsidy of $_____ per session.

- ✓ I have completed a Fee Subsidy Application and discussed this with my counselor.
- ✓ I understand my fee will be reviewed two times per year and if my financial situation changes.
- ✓ I completed demographic information due to funding purposes.

☐ I will be receiving sponsorship of my counseling and will be paying a reduced fee of $_____per session for _____ sessions.

- ✓ I have completed the Organization Sponsored Agreement Form.
- ✓ I understand that this will be reviewed near the end of the agreement.
- ✓ I completed demographic information due to funding purposes.

INSURANCE INFORMATION:

☐ I will be **using insurance and/or secondary insurance** that SamaraCare has contracted with to provide services or will be using out-of-network benefits. **Please provide Insurance Card. Complete and sign information:**

Primary Insured Name:_____Relationship:_____

Address (if different):_____ Date of Birth:_____

Phone:_____ Insured Soc. Sec. #:_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE –

- I authorize the release of any medical or other information necessary to process claims.
- I authorize payment of medical benefits to SamaraCare for services rendered.
- **I agree to pay the deductible, co-payment and/or co-insurance as indicated by my insurance company at the time of service.**
- **I ACCEPT THE FINANCIAL RESPONSIBILITY OF ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PROCESSED THE CLAIM**

_____ _____

Signature of Client Date

PLEASE COMPLETE THE BACK OF THIS FORM

Missed Appointments: Because counseling hours are reserved, SamaraCare charges for canceled and rescheduled sessions when less than 24 hours notice is given except in case of emergency. A full session fee ($165) will be charged as insurance does not reimburse for missed appointments.

Patient Balances: I am aware that I am responsible for my session fee or insurance co-pay, co-insurance or deductible **at the time of service.** I may pay with cash, check, or credit card. I understand I will be charged $20 if a check is returned for insufficient funds. If my account has an outstanding balance that has not had payment for 2 sessions, further sessions will not be scheduled unless approved by a supervisor.

Financial Communication: I release my financial account information to be shared with the following individual/s:

Name/Relationship:_____ Phone:_____

Name/Relationship:_____ Phone:_____

I understand and agree to the financial policies as stated.

_____ _____

Signature (18 & over) Date

_____

Printed Name

A copy of this form is available upon request