COLLABORATIVE CARE
Behavioral Therapy
LLC

AGREEMENT TO UTILIZE INSURANCE/THIRD PARTY PAYOR
and
FINANCIAL RESPONSIBILITY POLICIES

Financial Responsibility

Subject to applicable law and the terms and conditions of any applicable contract between CCBT and a third-party payor, and in consideration of all healthcare services rendered or about to be rendered to the client, I agree to be financially responsible and obligated to pay CCBT for any balance not paid under the "Assignment of Benefits/Third-Party Payors" paragraph below.

Assignment of Benefits/Third Party Payors

In consideration of all health care services rendered or about to be rendered to the client, I hereby assign to CCBT all right, title, and interest in and to any third-party benefits due from any and all responsible third-party payors of an amount not exceeding CCBT's regular and customary charges for the healthcare services rendered. I authorize such payments from applicable third-party payors. A list of usual and customary charges, or "fee schedule", will be available upon request. I consent to any request for review or appeal by CCBT to challenge a determination of benefits made by a third-party payor. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by a third-party payor. In consideration of CCBT's services received or to be received for medical and/or educational services, I assign to CCBT all benefits herein specified, not to exceed the CCBT charges. I direct third-party payor to pay such benefits directly to CCBT. I hereby agree to pay any and all CCBT fees that exceed or that are not covered by my third-party coverage including services and waive any and all notices and demands in the event of non-payment. I understand that by law and CCBT policy, I am obligated to pay all co-payments, coinsurance, deductibles, and other out of pocket expenses as contracted between me and my third-party payor.

Insurance Benefits

As a courtesy to me, CCBT will contact my insurance to determine my benefits and keep me informed on what is communicated to them. However, because CCBT staff does not work for the insurance company, I understand any questions I have regarding my coverage should be directed to my insurance company by calling the number on my insurance card. I understand that CCBT staff will attempt to give me the most accurate information possible, but final determination of my benefits lies with my insurance company and will be determined by them alone. I understand that any information conveyed to me by CCBT staff is based on their current understanding of what was communicated to them but is not a guarantee of coverage. Any discrepancy between the final determination of benefits and what was originally communicated to me by CCBT staff will be my financial responsibility.

Payment for Non-Reimbursable Items and Billing Information

I understand and agree to pay the charges incurred by me or the client for materials and/or services and hereby authorize CCBT to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same. I am aware that my billing statement will show charges for services that are in two categories, billable therapeutic services that are covered by the third-party and non-billable services that are not covered. This is regardless of the type of third-party. If the third-party does not cover the remaining balance, or if I do not have a third-party payor, the balance will be billed to me. Clients who have a third-party payor will be billed for balances monthly. For additional questions, contact Brittany McDonald at (937) 441-1782.

Private Pay

Private pay clients (those who do not have a third-party payor) will be granted a discounted flat rate of $60 per hour regardless of services being rendered. This includes services such as assessment, parent training, and ongoing therapy. Private pay clients will be billed on a weekly basis on the last day that services are rendered for that week unless other arrangements are made with and approved by our office ahead of time. I understand that if I am a private pay client, I will be expected to pay for services weekly.

Past Due Balances

I understand that prompt payment is expected when I receive a bill for services rendered. Per CCBT policy, if a client, regardless of whether they have a third-party payor or not, has outstanding past-due charges of $1,500 or more, services will be postponed until payment is made in full to Collaborative Care Behavioral Therapy. If a client has outstanding charges of $5,000 or more (even if the

balance is not past due), services may be postponed until payment is made to Collaborative Care Behavioral Therapy to bring the balance under $1,500. I understand this policy and agree to adhere to it. Further, if payment on past due balances would stop after services have been discontinued, CCBT has the right to take action in an effort to collect payment for services rendered to the client. This action may include, but is not limited to, referral of the client or parent/guardian to a collection agency and/or legal court action.

Returned Check Policy

There is a $60 fee for returned checks. If a check is returned, CCBT reserves the right to charge this fee to me, regardless of whether I have a third-party payor or not. Further, I understand that if I have third-party payor, this returned check fee is not billable to the third-party, so I will be solely responsible for that fee in its entirety. CCBT has the right to refuse to accept checks from me as payment should a check be returned, and I will be given the option of paying by cash as an alternative.

Payment/Notice of Privacy Practices/Certification

I certify that to the best of my knowledge and belief, the information provided is complete and correct. I authorize any holder of medical or other information about me or the client to release to the third-party payor, its intermediaries or carriers of any information needed for related claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to Collaborative Care Behavioral Therapy for services rendered. I understand that this consent is subject to revocation by me at any time in writing, except if the person or entity authorized to make a disclosure has already acted in reliance on this form. Otherwise, subject to applicable law, this consent will expire at the same time CCBT's record retention period for this document expires.

Additional Permitted Uses and Disclosures of Confidential Medical Information

I consent to the release of my and the client's health information and financial account information to all third-party payors and/or their agents that are identified by CCBT, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent CCBT or provide assistance to CCBT for the purposes of securing payment from all parties who are potentially liable for payment for the client's healthcare. I can revoke my consent in writing at any time except the extent that CCBT has already relied on my consent. I understand and consent to disclosure of confidential medical and/or educational information to a State or Federal Oversight Agency or an appropriate Public Health Authority for purposes required by State and/or Federal law, in cooperation with a Law Enforcement Investigation, in cooperation with a domestic or child abuse investigation, and for any other permissible purpose as outlined in the Notice of Privacy Practice and Confidentiality document.

Acknowledgment and Signature

I have read, fully understand, and agree to all terms set forth in this document. I certify that I am the **guarantor** (or person financially responsible) for payment of services rendered to the client by Collaborative Care Behavioral Services LLC. I agree to all releases of confidential medical information for the purposes of collecting payment and/or complying with State or Federal Law as described in this document. I agree to be held financially and legally responsible for any balance beyond what is paid by a third-party payor on the account of this client.

_____ _____

Printed Name of Client DOB

_____ Guarantor's Relationship to Client:

Printed Name of Guarantor ☐ Self ☐ Parent ☐ Guardian ☐ Other:_____

_____ _____

Signature of Guarantor Date

_____ _____ _____

Guarantor SSN Guarantor DOB Address of Guarantor (if different from client)