FINANCIAL AGREEMENT

Client's Name (print): _____ Client ID Number: _____ D.O.B:_____

Thank you for choosing SummitStone Health Partners ("SummitStone") as your behavioral healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. Please read and sign this form to indicate you understand our client financial policies.

Client/Guardian Financial Responsibility

As a client, or legal guardian, I understand that:

- I am ultimately responsible for the payment of treatment.
- SummitStone must be a contracted provider under my insurance plan for SummitStone to bill my insurance; I must provide correct and up-to-date insurance information at the start of treatment and as necessary throughout the course of treatment.
- I am responsible for providing proof of income prior to my initial evaluation **and** on at least a semi-annual basis to receive the best rate available if I choose to opt-out of using my insurance or do not have coverage. The information provided may qualify me to receive a discounted rate for services.
- I am responsible for all charges if the insurance or proof of income information I submit is not correct or becomes outdated.
- I am responsible for payment of co-pays, co-insurance, deductibles, and other costs for treatment that are not covered by my insurance plan.
- I will receive a monthly Client Statement from SummitStone outlining charges and payments.
- Payment for services will be required ***at the time of service***, depending on my insurance coverage and that I may pay for services with cash, check, or a major credit card.
- Payments received by SummitStone may be applied to any unpaid client balances for which I am listed as the responsible party. Payment may not reflect current receipt of payment on the date of service.
- I may call the SummitStone billing department at 970-494-9966 with questions regarding balances due and/or account credits.
- I may also be responsible for miscellaneous charges, including but not limited to:
    - Returned checks
    - Treatment manuals
    - Case management services
    - Peer Services
- If I am a minor client between the ages of 12 and 17 years old and I have claimed "Self" on the Medical Decision-Making (MDM) Form, I understand I am responsible for all self-pay fees unless an alternate method of payment is provided (e.g., insurance).
- I understand that if I do not have insurance coverage, I can pay a designated self-pay or discounted rate *ONLY* if my proof of income is provided and kept up to date on a semi-annual basis.

Household Information

- My annual household income is: $_____
- Total number of dependents, including client, in the household: _____
- Total number of dependents under the age of 18 in the household: _____
- I am receiving SSI Benefits: ☐ Yes ☐ No
- I am receiving SSDI Benefits: ☐ Yes ☐ No

CLIENT AUTHORIZATION

By signing below, I understand that:

- It is my responsibility to be aware of the requirements, coverage rules, deductibles, and other co-payments under my insurance plan.
- I am providing authorization for SummitStone to release necessary treatment information to bill my insurance company or other third-party payors.
- I am authorizing the assignment of financial benefits directly to SummitStone for services rendered and that I am financially responsible for any charges not covered by my insurance plan.
- Unpaid account balances may result in a delay of services (excluding crisis services).
- I must provide Proof of Income on at least a semi-annual basis to receive the best rate available to me.

I have read, understand, and agree to the provisions of this Financial Agreement. This agreement will be updated annually.

_____ _____

Signature of Client *or* Legal Guardian **Date**