

Date: _____

AREA MENTAL HEALTH CENTER FINANCIAL AGREEMENT

LAST NAME: _____ FIRST NAME: _____ M.I. _____

HOURLY SLIDING SCALE % _____ or MINIMUM FEE \$ _____

You may qualify for a discount based upon your family income and number of dependents. In order to determine any possible discount, proof of family income is required.

Annual Family Income: \$ _____

Number of Dependents: _____

Bill To: _____

Mailing

Address: _____

City _____

State _____ Zip _____

Telephone Numbers:

Home: _____

Work: _____ Extension: _____

Payment Method (Check those that apply)

- | | |
|---|--|
| <input type="checkbox"/> Private Pay | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> Voc-Rehab | <input type="checkbox"/> Railroad Medicare |
| <input type="checkbox"/> Blue Cross/Blue Shield | <input type="checkbox"/> Champus |
| <input type="checkbox"/> DDS | <input type="checkbox"/> VA |
| <input type="checkbox"/> EAP (Employer: _____) | |

Primary Insurance Carrier:

Insured person: _____

Date of Birth: ____/____/____

Social Security #: ____-____-____

Secondary Insurance Carrier:

Insured person: _____

Date of Birth: ____/____/____

Social Security #: ____-____-____

Eligibility Supplemental Determination (Please check one)	<input type="checkbox"/> Not Eligible
<input type="checkbox"/> Eligible and receiving payments	<input type="checkbox"/> Potentially Eligible (Case not yet submitted for determination)
<input type="checkbox"/> Eligible but not receiving payments	<input type="checkbox"/> Determined to be ineligible by review and decision

ALL OFFICE CALLS ARE ON A CASH BASIS UNLESS OTHERWISE ARRANGED

If you have insurance, your insurance will be billed at our usual and customary rates. AMHC also sets a co-pay amount and a private pay percentage based on a sliding scale determined by your income and number of dependents. ***It is understood that the co-pay is to be paid to the receptionist at the time of each appointment.***

Insurance: You will be responsible for your bill until you furnish us with your insurance information. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file the claim for you. If AMHC is not a participating provider with your insurance company and they have not paid within 90 days of the date of service, the balance is automatically transferred to your responsibility.

If your account is over ninety (90) days old and has had no activity in the recent sixty- (60) day period, it may be turned to a collection agency.

Release of Information: I assign benefits of my medical insurance contract, Medicaid or Medicare to AMHC and authorize payment directly to AMHC. I authorize AMHC to release medical information to payers as required for payment of claims for medical services.

Please notify AMHC of any changes in your health insurance carrier immediately.

The undersigned understands and agrees to the above financial conditions.

SIGNATURE

DATE

WITNESS

DATE