SUMMITSTONE
HEALTH PARTNERS

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, on at least an annual basis to receive the best rate available. The information provided may qualify me to receive a discounted rate for services that are not a covered benefit under my insurance plan.
- I am responsible for all charges if the insurance or proof of income information I submit is not correct or becomes outdated.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 may 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;
    - Copying and distribution of medical records;
        - Paper records
            - Flat fee of $18.53 for pages 1-10;
            - Additional print charges are as follows for more than 10 pages of paper medical records:
                - Pages 11-39 are $0.85 per page
                - Pages 40 + are $0.57 per page
        - Electronic records
            - Flat fee of $6.50
    - Treatment manuals;
    - Case management services.
    - No show appointments without notice provided by the business day prior to the appointment will incur a $25.00 charge.

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SELF-PAY RESPONSIBILITY

I attest that my annual household income is $_____. This income supports _____ individuals (total number of dependents, including client, in the household). The number of dependents under 18 years of age in the household is _____.

I am receiving SSI Benefits ○ YES ◉ NO
I am receiving SSDI Benefits ○ YES ◉ NO

- 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 liable 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 an annual basis.
- I understand I am required to provide proof of income prior to my initial evaluation, and that I must provide proof of income on at least an annual basis to receive the self-pay or discounted rate for services.

Below are *estimated* amounts for *each* service, WITH proof of income, and WITHOUT proof of income.

***WITH** proof of income (based on annual income, and number of dependents it supports):

GROUP: $_____ INDIVIDUAL: $_____ MEDICAL PROVIDER: $_____

***WITHOUT** proof of income:

GROUP: $ 50.00 - $175.00 INDIVIDUAL: $ 140.00 - $230.00 MEDICAL PROVIDER: $ 230.00 - $310.00

**Sliding fee scale and standard rates are subject to change.*

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 be sent to collections and/or may result in an interruption of services (excluding crisis services).
- I must provide Proof of Income on at least an 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**