COMPASSIONATE BEHAVIORAL HEALTH

Patient Financial Responsibility and Self-Pay Waiver Form

Thank you for choosing Compassionate Behavioral Health for your medical needs. We are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due after your insurance(s) have responded.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

I understand that the above is an estimate of the cost for today' s visit, and that based upon actual services provided, the actual cost may be higher or lower. I understand that by signing this acknowledgement I will be responsible to pay for all of the providers' charges for the services rendered to me.

Patient Name: _____ Date of Birth: _____/_____/_____

The patient (or patient's guardian) is ultimately responsible for the payment for treatment and care.
PLEASE CHECK ONE BELOW:

C] I am currently uninsured and therefore I am responsible for full payment of all services.

Cl Check here if you elect to use available medical insurance for visit coverage. Self-pay rates will not apply after date of service.

Patient Signature: _____ Date: _____

Patient Printed Name: _____