COMMUNITY REACH CENTER
CONSUMER FINANCIAL FORM

FEE AGREEMENT **ASSIGNMENT OF BENEFITS** **RELEASE OF INFORMATION**

Date:	Consumer Account Number:
Consumer's Last Name:	First Name: M.I.
Consumer's Soc. Sec. Number:	Consumer's Date of Birth

PERSON FINANCIALLY RESPONSIBLE

( ) Self	( ) Spouse	( ) Dependent	( ) Parent/Guardian	( ) Other:
Last Name		First Name		M.I.
Street Address			Apartment/Space Number	
City	State	Zip Code	Head of Household (Check One) ( ) YES ( ) NO	
Home Phone Number:		Work Phone Number and Ext:	Employer:	

PRIMARY INSURANCE INFORMATION

Copy of insurance card (front & back) attached

Insurer's Relationship to Consumer: (Check One)

( ) Self	( ) Spouse	( ) Dependent	( ) Parent/Guardian	( ) Other:
Medicare Number:	Medicaid Number: County		CORE Household Number:	Other:
Insured's Soc.Sec. Number		Insured's Last Name	First Name	M.I.
Insurance Co. Name		Insurance Phone Number:		
Mailing/Street Address		City	State	Zip Code
Policy Number:	Group Number		Authorization Number *(If required)*	

SECONDARY INSURANCE INFORMATION

Copy of insurance card (front & back) attached

Insurer's Relationship to Consumer: (Check One)

( ) Self	( ) Spouse	( ) Dependent	( ) Parent/Guardian	( ) Other:
Medicare Number:	Medicaid Number: County		CORE Household #:	Other:
Insured's Soc. Sec. Number:		Insured's Last Name	First Name	M.I.
Insurance Co. Name		Insurance Phone Number:		
Mailing/Street Address		City	State	Zip Code
Policy Number	Group Number		Authorization Number *(If required)*	

I have reviewed the Consumer Financial Form above and the Fee Billing Policies and Financial Agreement for the Center. I have completed the requested information completely and to the best of my knowledge. I have received a copy of this form and as well as the fee policy agreement and agree to its terms. I agree to assume responsibility and pay the Center the assigned fee.

RELEASE OF INFORMATION
I authorize Community Reach Center to release information for insurance purposes as may be required by the insurance company.

AUTHORIZATION OF BENEFITS
I authorize payment to be made to directly to Community Reach Center.

Signature of Consumer/Parent or Guardian **Date**

Signature of Insured **Date**

FOR OFFICE PURPOSES ONLY – TO BE COMPLETED BY COMMUNITY REACH CENTER STAFF		
Gross Annual Household Income: $	**No. of Dependents:** **No. of Child Dependents:**	**Fee Per Session:**

Community Reach Center, Inc.
Fee Policy and Financial Agreement

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

Community Reach Center, Inc. (CRC) is a non-governmental, not for profit organization that relies on fees and insurance payments for a major portion of its operating expenses. You are ultimately financially responsible for all services you or members of your household receive from the Center.

If you have insurance, Medicare or Medicaid, we require you to:

- Provide a copy of your CURRENT Medicaid card (front and back) at the time of each visit or at least once a month thereafter. Failure to provide a copy of your current card could result in being charged full rate for services. Services are available to you as long as you continue to reside in Adams County and remain eligible for Medicaid services. If you reside outside of Adams County, CRC is responsible to provide emergency services only until we receive a prior authorization from your primary provider. Your primary care physician (PCP) will be notified you are receiving mental health services.

- Provide CRC with any insurance claim form(s) from your employer, insurance agent or company with required information filled in and/or a copy of your insurance card (front and back). Verification of insurance benefits is not a guarantee of payment. The contract for your insurance is between you and your insurance carrier. We will assist you in every way possible to receive payment from them. However, you are ultimately responsible for payment. You are responsible for any/all deductibles and copays.

- Provide a copy of your Medicare card at the time of each visit or at least once a month which reflects whether you are eligible for services under your Medicare Part B insurance. Services provided by Physicians, Licensed Psychologist or Licensed Therapist who are supervised by a physician or psychologist present and available on the premises at the time services are rendered. You are responsible for any/all deductibles and copays not covered by Medicare.

- If at any time your coverage changes, it is your responsibility to notify CRC. Failure to do so could result in the fees billed to you instead of Medicaid, Medicare, your insurance company, special grant or other third party payor.
- In the event additional services are requested or required that are not covered under your insurance or payor plan, you will be solely responsible for those services.

Fee/Billing Policies:

- It is your responsibility to notify CRC of any changes in your financial situation during the term of this agreement. Failure to do so may result in the termination of this agreement and/or changes in your fee.
- At the time of intake, you will be asked to complete a financial statement, if requesting a reduced fee. This reduced fee will be in effect as long as the account remains current. This fee agreement will remain in effect for 1 year unless otherwise noted. An annual review is required on each consumer's account.
- CRC policy states that consumers who fail to pay for three (3) sessions are at risk of termination of services. The decision to terminate services will be based on both clinical and financial information.
- A NO SHOW fee of $15.00 will be charged if you fail to notify CRC, at least 24 hours prior to your scheduled appointment. This fee will be due at your next appointment.
- Payment is expected prior to any psychological or interactional evaluation for all self-pay consumers.

Delinquent Accounts:

- In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.