 **Financial Agreement**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gross Monthly Income: |  | Number of Dependents: |  | % of unit Fee: |  |
| [ ]  **Private Pay** | [ ]  **Insurance** |
|  | **Primary Insurance** |  | **Secondary Insurance** |
| Insurance Company Name: |  |  |  |
| Insurance Company Address: |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Insurance Company Phone Number: |  |  |  |
| Subscriber’s Name/Relationship: |  |  |  |
| Subscriber’s Date of Birth: |  |  |  |
| Subscriber’s ID #: |  |  |  |
| Insured ID # (Dependent): |  |  |  |
| Group Name / #: |  |  |  |
| Employer: |  |  |  |
| I (We) understand that COMPREHENSIVE HEALTHCARE will bill my (our) insurance company at full fee rate. I (We) will be responsible for any amount not paid by the insurance up to co-payment amounts or percentage of the unit fee.For those that are unable to pay, I understand Comprehensive Healthcare has a Sliding Fee Discount Program that is based on gross income and family size. Individuals with gross incomes at or below 200% of the Federal Poverty Guidelines may qualify for the discount. Applications for the Sliding Fee Discount Program are available at the front office and on our website, comphc.org. To be eligible for this program I understand it is my responsibility to complete the application and submit the required documentation.  |
| [ ]  | **MEDICARE** | **Medicare Lifetime Authorization** |
| HIC:  |  | Authorization Period From |  | to |  | \* |
| **\* or until rescinded. I permit a copy of this authorization to be used in place of the “original”** |
| **PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR PRIVATE PAY AND/OR INSURANCE CLIENTS**This document does not obligate me to receive services. If I do receive services, I understand that my signature upon this document shall be treated as a contract. If the terms of this contract are not met, services may be suspended or terminated and my account may be referred to a collection agency. I also acknowledge receipt of a current list of services with associated fees and understand that these fees may change during the course of treatment. There will be advance notice of a fee change. My signature below indicates that I have received a copy of the COMPREHENSIVE HEALTHCARE Financial Policy. |
| **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**I hereby authorize payment of benefits to be made directly to COMPREHENSIVE HEALTHCARE for services provided. I authorize COMPREHENSIVE HEALTHCARE to release information on my behalf to facilitate third-party payment for service I have incurred. I understand that I am financially responsible for any charges not covered by this assignment. |
|  | **X** |  |  |  |
| Comprehensive Healthcare Representative Signature |  | Responsible Party/Guarantor Signature |  | Date |
|  | Name: |  |
|  |  | \*Please print Responsible Party Name & Address |
|  | Address: |  |
|  | City: |  | State: |  | Zip: |  |

|  |  |
| --- | --- |
| **Comprehensive Healthcare** | Client Name: |
| Client ID Number: |
| Date of Birth: |
| CMH-500 (11/1/2024) |