FINANCIAL AGREEMENT

Adult client or guardian of minor client should sign

Client: _____ **Birthdate:** _____

RELEASE OF INFORMATION: I authorize Adapt Behavioral Services to release relevant confidential information to my current funding source in order to process claims, obtain reimbursement, and comply with the funding source's auditing requirements.

OTHER INSURANCE: I understand that publicly funded insurance (Medicaid, Healthy Kids) is payor of last resort and any other coverage must be used first. I understand that I will be responsible for all charges if I fail to disclose other insurance coverage for the above-named client.

FINANCIAL RESPONSIBILITY: I understand that I will be responsible for all charges that my funding source does not cover, including services not covered in my plan, services in excess of the allowable amount in the plan, services provided after coverage lapsed, fees described in the *Cancellation/No Show Policy*, or any other reason for insurance non-payment.

My current insurance coverage includes the following (actual cost may change after insurance processes claim):

☐ **No cost:** I understand that my insurance plan has no deductible, coinsurance, or copayment.

☐ **Deductible**: I understand that my insurance plan has a deductible and that I will be required to pay the entire cost of services until the deductible amount has been met. ***Deductible details:*** _____

☐ **Coinsurance**: I understand that my insurance plan requires me to pay a percentage of the total charges for services (after the deductible has been met, if the plan has deductible). ***Coinsurance details:*** _____

☐ **Copayment**: I understand that my insurance plan requires me to pay a flat rate for each date of service (after the deductible has been met, if the plan has deductible)***. Copayment details:*** _____

NOTE: During the assessment and reassessment periods, there may be additional charges for indirect services related to assessment (e.g., data analysis, report writing) outside of sessions.

I agree to pay for my share of the cost of services in the following manner:

☐ **CASH/CHECK/MONEY ORDER**: I will give the payment to the clinician at the end of each IN-PERSON session

☐ **CREDIT/DEBIT CARD**: I authorize Adapt Behavioral Services to pay for my services using the credit or debit card below (Minimum charge: $5)

CREDIT/DEBIT CARD AUTHORIZATION

Credit card type: ☐Visa ☐Master Card ☐Discover (we do not accept American Express)

Credit card #: _____ **Expiration Date:** _____ **Security Code:** _____ **Zip code:** _____

Authorizing Signature: _____

INSUFFICIENT FUNDS: I understand that if my check is returned for insufficient funds, I will be responsible for paying any fees charged to Adapt by the bank. I further understand that I will no longer be able to pay by check and will have to use another payment method (e.g., credit card, cash, money order, Zelle).

CREDIT CARD DENIAL: I understand that if my credit card is denied, I will have to use another payment method (e.g., check, cash, money order)

This agreement may be amended or terminated at any point. Termination of this agreement does not relieve the obligation to pay for services that have already been rendered.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

Client/Guardian Signature: _____ **Date:** _____

Guardian Name (printed): _____ **Relationship:** _____
(required if client is a minor)