Financial Responsibility Form

Patient Name: _____ **Date of Birth:** _____

Dear Parent or Guardian:

Services rendered are the financial responsibility of the Patient's Parent or Guardian. The Patient is responsible for payment regardless of insurance coverage. Billing information will be provided to the insurance carrier to expedite patient reimbursement from private insurance carriers.

Your policy may ask you, the subscriber, to pay a deductible, a co-insurance, or co-pay amount and may have certain non-covered services. We accept the allowable only for those carriers with whom we participate. We will make reasonable attempts to collect the approved benefits from your carrier for a period of 30 days. However, please remember that you are ultimately responsible for your medical bills. You will receive a monthly statement showing the amount that is your responsibility. A fee of $25.00 is charged for all returned checks.

For your convenience, our business office accepts Master Card, Visa, debits from a checking or saving account, and personal checks. We will file directly to your insurance company for the charges incurred at Clarity Child Guidance Center. Individual insurance companies determine allowable fees based on their specific plan. Payment for a service is based on the allowable amount determined by your insurance company and will vary depending on your policy. Please contact Patient Financial Services at (210) 616-0300 if you have any questions.

OUTPATIENT RATES: Intern: $80 Master's Level Clinician/PLP: $130.00 **(per hour)**
Ph.D.: $160.00 **(per hour);** Psychological Testing: $160.00 **(per hour)**
Medication Evaluation: $210.00 Medication Management: $75.00

INPATIENT RATES (per day): Acute: $1,850.00 RTC: $1600.00 PHP: $800.00

I understand, acknowledge and agree that I am responsible for payment of any healthcare services provided to the extent not covered or reimbursed to Clarity Child Guidance Center by my health insurance including, but not limited to, applicable co-payments or co-insurance, sales taxes, laboratory or radiology fees. I further acknowledge that such payments will be at their usual and customary rates to the extent allowed by law. I understand that the decision to proceed in light of any non-coverage and non-payment by the plan is mine and mine alone, and I understand the consequences of not proceeding with the service. I further agree that the foregoing agreement supersedes any prior agreement entered into by me or on my behalf.

By signing this form, I certify that I have read the above statement and understand my financial responsibility for services rendered by Clarity Child Guidance Center.

_____ _____
Parent / Guardian Signature Date

_____ _____
Witness / Staff Signature Date