LIFESKILLS, INC

FINANCIAL AGREEMENT

Patient Name: ____________________________ Social Security: ____________________________

LifeSkills, Inc. is a not for profit organization dedicated to providing quality outpatient services for behavioral health and intellectual and developmental disabilities. Along with outpatient services and case management services LifeSkills, Inc. offers a variety of services including inpatient and enhanced outpatient for substance use disorders, adult and children Crisis Stabilization, and 24/7 Emergency Services which you can reach by calling 1-800-843-HELP in an immediate crisis. In order to provide these services to all in need, we must inform you of your financial obligations and options.

It is the policy of this office that payment in full is expected at the time services are rendered if any of the following circumstances apply:

- You are a self-pay patient. (You have no medical insurance)
- Your therapist is not a participating provider with your insurance/managed care plan.
- You do not wish to have your insurance billed or you have not given us all of the current/correct information required to file an insurance claim.
- Your insurance benefits do not cover the service rendered (it is your obligation to know your coverage).
- Your insurance company denied authorization of your therapists recommended testing/treatment plan and you elect to self-pay and proceed with the recommended testing/treatment.

I hereby assume financial responsibility for and agree to make payment in full to LifeSkills, Inc. for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Any amount paid in excess of the full amount for charges will be applied to any cuurent charges or refunded upon completion of services. Deductibles and/or co-payments are required at the time services are rendered unless payment arrangements are made with a representative of LifeSkills, Inc.; prior to the time services are rendered. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, LifeSkills, Inc. to investigate any and all financial information given concerning this or related claims. I understand and agree to inform LifeSkills, Inc. of changes in my insurance at the time of service so that claims can be filed within the insurance carrier's deadline. I further understand and agree that I will be responsible for the full fee for services rendered but not covered by my insurance carrier.

I understand that an insurance company may send an Explanation of Benefits (EOB) and or payments directly to the policy holder. I am aware that I am responsible for notifying LifeSkills, Inc. if this occurs. Failure to do so may require me to assume all financial responsibility for the services provided.

I further authorize LifeSkills, Inc. to file claims to any third party liability reported by Centers for Medicaid Service (CMS).

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Signature of Client or Representative Date

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Witness Date