Christian Health Care Center

FINANCIAL AND SERVICE AGREEMENT FOR MINORS

Important financial document, please read carefully.

Patient name (Print) _____

I/we do hereby agree to pay Christian Health Care Counseling Center (referred to as "CHCCC") the full and entire amount of any and all costs for treatment or other services related to my care or that of my dependent.

I/we understand that CHCCC cannot guarantee that my hospital/medical insurance coverage will be adequate to pay for all services rendered by CHCCC. I/we also understand that I/we are responsible for complying with my insurer's requirements (including, but not limited to, pre-treatment authorization) regarding my coverage. If my insurer denies coverage, I/we agree to be responsible to CHCCC for payment of all bills related to my care. I/we will be responsible to pay the balance of any bills not paid by insurance in accordance with CHCCC standard billing terms, which require payment in full of all charges billed by the 20th day of the month following the month in which the bill was issued. I/we agree to make payments of co-pay, deductibles, or set fees at time of each visit/treatment.

I/we understand that if I/we cancel an appointment less than 24 hours in advance or miss an appointment, I/we may be charged a $25 cancellation fee, which may not be covered by my insurance.

I/we understand that failure to make payment in accordance with this agreement will result in the assessment of finance charges at the rate of 1 ½ percent per month on unpaid balances, which I/we will be responsible to pay. Should it be necessary for CHCCC to engage an attorney or collection agency for the purpose of collecting such unpaid balances, I/we agree to pay for any and all related costs and fees.

I/we hereby authorize CHCCC to release any medical information acquired in the course of my examination or treatment which may be needed to process a claim for medical insurance benefits.

Any violation of the terms of this agreement shall be just cause for the termination of CHCCC obligation to provide further services to me. Based upon such violations, I/we may be referred to another provider.

Assignment of Benefit - I/we hereby authorize payment directly to CHCCC the insurance benefits otherwise payable to me for treatment provided by CHCCC. I/we agree to remit to CHCCC any payment made directly to me for these services, to be applied to my outstanding balance until CHCCC is paid in full.

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Guarantee of Payment

In order for CHCCC to enter into a Financial and Service Agreement (the "agreement") with_____ (the "client") the undersigned ("client/guardian") hereby guarantees to comply with all applicable policies and procedures of client/guardian, including but not limited to the client/guardian's responsibility for payment of co-payments, deductibles, and non-covered charges. If the client/guardian fails to notify CHCCC of a change in insurance coverage, the client/guardian will be held responsible for any resulting balance due. This agreement is unlimited, continuing, and absolute with respect to each of the terms and conditions and obligations of the client/guardian under the agreement. The client/guardian agrees that the institution may proceed to bill and/or collect payment for services rendered.

Separated/Divorced Parents

In the case of a minor child of separated/divorced parents, the following procedures shall apply: In order for a minor client whose parents are separated or divorced to be admitted for outpatient services, the consenting parent(s) must indicate custodial and financial responsibility on the outpatient Potential Client Form. Should both parties have the right and responsibility to consent to and support treatment of the minor, both parties/parents should provide signed consent to treatment and financial agreement on behalf of the minor(s) unless otherwise agreed by the involved parties. Should only one parent consent and agree to treatment and financial responsibility for the minor, the responsibility to pay for care rendered and to provide any additional consent required shall be imposed on the consenting parent. It is the responsibility of the separated/divorced parents to accurately represent custodial and financial responsibilities and rights and obtain necessary signatures prior to treatment.

_____

Patient name

I/we have read and understand the Finance and Service Agreement.

_____	_____	_____
Parent/guardian	Date/Time	Witness
_____	_____	_____
Parent/guardian	Date/Time	Witness

REFUSAL TO SIGN THIS FORM WILL RENDER THE CLIENT RESPONSIBLE FOR PAYMENT!

_____	_____
Authorized personnel	Date/Time