LIGHTHOUSE PSYCHIATRY

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

PATIENT NAME: _____ **DATE OF BIRTH:** _____ (MM/DD/YYYY)

The medical services that are being rendered today may not be covered by your insurance company for one of the following reasons. This does not mean that you cannot receive medical services. By signing this Financial Responsibility Acknowledgement, you acknowledge full responsibility for all cost of services rendered.

1. Services rendered may not be considered eligible for benefits by your health plan.
2. We are unable to verify benefits or confirm eligibility by your health plan due to after hours or insurance card not present.
3. You do not want to or have health insurance and decided to be a self-pay patient.
4. We do not have the required referral or authorization for services rendered today.
5. We are contracted with your primary insurance; however, we are not contracted with your secondary insurance.
6. Services may be considered out of network.
7. Your insurance carrier will determine what services are covered. You may contact your insurance company directly for questions regarding coverage policies.
8. We are not AHCCCS providers. Hence, we do not submit claims to AHCCCS.
9. FINANCIAL AGREEMENT: The undersigned agrees, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to promptly pay the account in accordance with predetermined rates and terms. Should any account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
10. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned assigns and authorizes direct payment to LIGHTHOUSE and affiliate of any insurance benefits otherwise payable to or behalf of the patients for services rendered. It is understood by the undersigned that he/she is financially responsible for charges not paid according to this agreement.
11. HEALTH PLAN (INSURANCE) OBLIGATION: It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided.
12. It is the responsibility of the undersigned to determine if the clinic providers have a contract with patient's health plan, if applicable.
13. Patient authorizes and request that insurance payments be made directly to LIGHTHOUSE when using my health insurance carrier.
14. Any disputes of covered benefits are solely the patient's responsibility to resolve with patient's insurance company.
15. It is patient's responsibility to update LIGHTHOUSE of any changes to patient's insurance information and status, including, but not limited to, policy, ID, carrier, subscriber, address, or any other information.
16. Patient is solely responsible for keeping track of scheduled appointments, scheduling obligations, and fees accrued for missed appointments.
17. NO SHOW/LATE CANCELLATION policy: a $150 FEE for INTAKES and $100 for FOLLOW-UPS. Payment is due by invoice or prior to next rescheduled appointment. Fees are not covered by insurance and are strictly patient responsibility. Late Cancellation is defined as, but limited to, cancellation of appointment under 24-hours from scheduled appointment, after 12pm on a Friday before a scheduled Monday appointment, 15-mintues after a scheduled intake appointment, 8-minutes after a scheduled psychiatric follow up appointment, or 15-minutes after a scheduled therapy appointment. Terms of Late Cancellation is subject to change without notice.
18. Not all fees are covered by insurance, including, but not limited to, medical records, no show/late cancellation fees, and other admin fees.
19. ALL RATES, FEES, COSTS, AND CHARGES ARE SUBJECT TO CHANGE AT ANY TIME WITHOUT NOTICE.
20. ALL PAYMENTS ARE DUE PRIOR TO SERVICES BEING RENDERED AND/OR SCHEDULING OF FUTURE APPOINTMENTS. These payments include, but not limited to, co-pays, deductibles, co-insurance, incurred administrative fees, no show/cancellation fees, court-related fees, attorney-based fees, collection fees, or any other outstanding balances.
21. DEBIT/CREDIT CARD INFORMATION: The undersigned agrees to store his/her debit/credit card information on file for convenient payment of charges accrued. Information to be stored in secure server. Information to be used on today's and future transactions. Information to be stored for one (1) year and will renew at the one-year anniversary, unless otherwise directed to terminate agreement by written order. Information may be removed at any time prior to anniversary by written order. CARD INFORMATION WILL BE STORED SECURELY: (A) IN A SECURE ON-SITE LOCATION, (B) ON A SECURE ELECTRONIC MEDICAL/HEALTH RECORD COMPANY'S SERVER, AND (C) ON A SECURE CREDIT CARD PROCESSING COMPANY'S SERVER. Internal privacy and security manager will routinely surveillance and monitor for breach of security and personal and financial information. Undersigned will be immediately notified of any known breach and/or leak of personal financial information.
22. DEBIT/CREDIT CARD AUTHORIZATION: The undersigned agrees to have debit/credit card charged for all services rendered, administrative fees, delinquent balances, and other fees not covered or not reimbursed by insurance company. Authorization will remain in effect until (a) undersigned no longer an active client of LIGHTHOUSE, and (b) all accrued debt to the company is paid off.

CARD INFORMATION	
[ ] DEBIT CARD [ ] CREDIT CARD	[ ] MASTERCARD [ ] DISCOVER [ ] OTHER: _____ [ ] VISA [ ] AMEX
CARDHOLDER FULL NAME (as shown on card):	
CARD NUMBER:	
EXPIRATION DATE (MM/YYYY):	
SECURITY CODE:	
BILLING ZIP CODE:	

All charges that have been explained to you are based on "Good Faith" estimate.

I understand that my health insurance coverage has certain restrictions and limitations such as authorization requirements, non-covered services, and/or no out-of-network benefits. Since I have chosen to obtain the services rendered today. I agree to be financially responsible for all related charges if they are not covered by my insurance.

I understand my financial responsibility listed in this document.

Patient/Legal Representative Signature Date Time

Legal Representative Name Relationship Social Security Number