CLARKSTON FAMILY THERAPISTS, LLC

PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

We are pleased to assist you by billing for our contracted insurers, the purpose of this form is to help you understand about insurance, eligibility, coverage, our office policies and services. Your signature below forms a binding agreement between Clarkston Family Therapists, LLC and the patient who is receiving services, or the Responsible Party for minor patients.

It must be understood that:

- **We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.**
- **Authorizations for treatment and/or testing from your insurance company/doctor do not guarantee full payment for the service.**
- **Not all insurance companies/third party payors pay for all services, or amount of coverage.**
- **All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.**
- **Patients are personally responsible for knowing and understanding their own Insurance Policy, Eligibility and Coverage.**
- **Patients are responsible for payment of outstanding Deductibles and Co-insurance amounts at time of service. Co-payments will be collected at the time of service.**
- **Patients are financially responsible for payments of all non-authorized procedures and non-covered services.**
- **Appointments that are missed or not cancelled more than 24 hours in advance will incur a $60.00 charge.**
- **Returned checks are subject to a $25.00 fee in addition to the original check amount.**
- **Should collection proceedings become necessary to collect an overdue account, the patient understands Clarkston Family Therapists, LLC has the right to disclose to an outside collection agency all relevant information necessary to collect payment for services rendered.**
- **Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.**

The Patient or Patient's Legal Representative hereby acknowledges that he/she is eligible for health insurance benefits and coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of services, and agrees to pay all the charges to the Provider accordingly.

Patient (Child's) Name_____
Please print

Responsible Party_____
Please print

Responsible Party Signature_____