Client Name _____ SSN/ID Number _____

**CUMBERLAND RIVER BEHAVIORAL HEALTH INC. P.O. BOX 568**
**CORBIN, KY 40702**
**(606) 528-7010**

## SERVICE FEE AGREEMENT

### ELIGIBLE PAYOR SOURCES AND YOUR FINANCIAL RESPONSIBILITY

This explains your responsibilities concerning your bill and any insurance or other payor source you may have. Please read this agreement carefully and ask any questions you may have concerning it.

**INSURANCE:**

1. Services covered by your insurance will be billed by our agency to your insurance company.
2. You will be responsible for paying any co-payment expenses and/or deductible amounts. Clients residing in the state of Kentucky may be eligible for a reduced fee based on their self-pay rate. The amount due will be calculated at the time of service and payment is due at the time of service.
3. You will be responsible for your self-pay rate (see below) of services not covered by your insurance.
4. You must submit to our agency all PAYMENTS and EXPLANATION OF BENEFITS or NON-PAYMENT you receive from your insurance company. If you fail to submit to our agency insurance payments or other materials you receive from the insurance company, you will be responsible for paying the full charge for services rendered.
5. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

**MEDICAID:**

1. Services covered by Medicaid will be billed by our agency to Medicaid.
2. Our agency will accept Medicaid payment as payment in full except for continuing income amounts. You will be responsible for all spend down and continuing income amounts due, as determined by Medicaid.
3. You will be responsible for presenting proof of eligibility (up-to-date Medicaid card) at the time of service.

**SELF PAY:**

1. All clients are responsible for paying our agency's full charge for services rendered.
2. Clients residing in the state of Kentucky may request a reduced fee, based on family size and income amount (proof of income is required) of the person responsible for payment.

**INSURANCE CLIENTS ONLY:**

1. I authorize CRBH to contact the subscriber to the insurance policy as necessary.
2. I authorize payment of Medical Benefits to CRBH for services rendered.
3. I authorize the release of information necessary to process my claim.

**COST OF THE SERVICE:**

1. **Outpatient: $ _____**
2. **Residential: $ _____**
3. **Assessment for Driving Under the Influence: $ _____**
4. **Assessment for Suboxone Clinic: $ _____**
5. **Parenting Classes: $ _____**
6. **Case Management: $ _____**
7. **Intensive out Pt.: $ _____**
8. **Other Services: $ _____**

**Other Services Description:**

Client Name _____ SSN/ID Number _____

**INCOME ATTESTATION:**

I do hereby state that my family income is as stated on the original application for services and/or subsequent updates. Whether signing as client or responsible party, I have read, understand, and agree to the above service fee agreement. I guarantee payment for all charges to this client. I understand no further appointments will be scheduled for the client until all amounts due by me are paid in full. This Service Fee Agreement will be reviewed annually or as deemed necessary by the agency. **By signing below I am also indicating that I have received a copy of this form indicating my payor source and amount due each visit.**

| _____ | _____ | _____ |
|---|---|---|
| Client Signature | Responsible Party's Signature | Date |

**INCOME VERFICATION DENIAL: I DO HEREBY STATE THAT I REFUSE TO DISCLOSE MY FAMILY INCOME AND UNDERSTAND BY DENYING DISCLOSURE, I FORFEIT MY ELIGIBILITY TO RECEIVE SERVICES OTHER THAN LIMITED CRISIS SERVICES WITH CUMBERLAND RIVER BEHAVIORAL HEALTH.**

| _____ | _____ | _____ |
|---|---|---|
| Client Signature | Responsible Party's Signature | Date |

| _____ | _____ | _____ |
|---|---|---|
| Witness Signature | Responsible Party's SSN | Date |