LIVING WELL BEHAVIORAL HEALTH, INC.

FINANCIAL ACCEPTANCE FORM

YOU ARE EXPECTED TO PAY YOUR CO-PAY, DEDUCTIBLE, CO-INSURANCE, AND ANY PAST DUE BALANCE ON YOUR ACCOUNT AT THE TIME OF SERVICES.

THANK YOU.

We will make your payment as easy and convenient as possible. You may pay by cash, check, credit card, or debit card. Please be aware returned checks will incur a $35.00 processing fee and payment must be paid before your next appointment. Please read the following and sign at the bottom to accept these terms.

I, _______________________________, agree to pay my co-pay, deductible, co-insurance,
(Client Name Printed)

and any past-due balance on my account at the time of service. I recognize that non-payment of fees will result in Living Well rescheduling my appointment.

Assignment of Insurance Benefits: I hereby authorize payment directly to Living Well Behavioral Health, Inc. and all health care providers involved in my treatment or diagnosis at Living Well Behavioral Health, Inc. by the group insurance, major medical insurance, and any other insurance payable to or on behalf of the undersigned, by virtue of outpatient services of the below named patient. I unconditionally assign any insurance benefits to Living Well Behavioral Health, Inc. and all health care providers involved in my treatment. I understand that **I am financially responsible to Living Well Behavioral Health, Inc. for all charges not paid by insurance.** If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt.

Client or Responsible Party Signature: ____

Date signed: _________________________