Comfort Minds & Above Behavioral Health
9500 Ray White Rd Ste 200
Fort Worth, Texas, US - 76244

*Financial Responsibility and Consent to Treat Policy

Dear Client,
Welcome to Comfort Minds & Above Behavioral Health!

We look forward to addressing all your mental health needs. We encourage your questions and participation in all aspects of your care.

Please make sure to read through this document in its entirety, mark each box appropriately, and insert your signature at the bottom.

1. Financial Responsibility

Will you be using a third party insurance to pay for services? *

☐ Yes ☐ No

Primary Insurance Details

Insurance Type *

☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS
☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG
☐ OTHER

Insurance Plan Name or Program Name * _____

ID * _____

Insurance Company Name (Payer Name) * _____

Payer Id * _____

Payer Address _____

Payer City _____

Payer Country _____

Payer State _____

Payer ZipCode _____

Valid From

Valid Until

Policy Group/FECA # _____

Copay _____

Deductible _____

Employer/School Name _____

Comments

Insured Person Details

Patient Relationship * ☐ Self ☐ Spouse ☐ Child ☐ Other

First Name * _____

Last Name * _____

Date of Birth * _____

Sex * ☐ Male ☐ Female ☐ Unknown

Address Line 1 _____

Address Line 2 _____

City _____

Country _____

State _____

Zip Code _____

Home Phone _____

Mobile Phone _____

Will you be paying for treatment with cash, debit/card? * ☐ Yes ☐ No

2. Financial Disclosures

3. Financial Responsibility for Direct Payment (No Insurance Participation)

For those requesting to submit to their insurance company directly, if appropriate or allowed by your plan, payment is due at the time of visit and you will receive a bill outlining your services for your submission to your carrier. Fees are due at the time of visit. * ☐ I understand

4. Financial Responsibility for Payment with Health Insurance

It is important for you to be an informed consumer, who understands the specifications of your insurance policy (e.g., doctor visit coverage, referral/authorization requirements for specialty care, radiographs, laboratory tests, urgent care facility care). If you have questions, please reach out to your plan provider. We will bill your primary insurance carrier IF WE ARE CREDENTIALED with the carrier. As a courtesy, we will also bill your secondary insurance carrier if we are credentialed with the carrier. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are ultimately financially responsible for payment of medical services rendered. After 60 days, any unpaid balances by insurance companies will become client/patient responsibility. You are responsible for assisting our staff in obtaining any referrals or pre-authorizations that may be required by your insurance plan prior to your appointment or those services being rendered. For MEDICARE patients that receive or participate in any medical services eligible under MEDICARE, we are required, by law, to collect all patient responsibility fees, co-pays, etc. MEDICARE may not cover some or all of the services we provide. For non-covered services, you will be informed prior to services rendered and provided with an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide

☐ I understand

whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances. If your insurance policy has provisions such as deductibles, co-insurance or co-payments please note that these are provisions that have been agreed to between you and your insurance carrier. We cannot legally discount fees after their submission on your behalf to your insurance carrier. Of note, we have contractual obligations to collect the balances as outlined by your insurance carrier. Writing off or dismissing patient responsibility balances could jeopardize our contract with your insurance carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out of pocket maximum will not have been correctly calculated. We will collect a fee for provided or offered services NOT covered by your insurance provider HSA or FSA funds may or may not be used to pay for the fee, depending on your plan. Please refer to your plan information for specific rules for use of HSA/FSA. We are not responsible for inaccurate information provided to us by your carrier. Please notify us in person, by phone, mail, our patient portal (preferred), or email any time you have a change in your insurance or billing information. If you lose insurance coverage, we must be notified immediately.
*

5. Refunds

A refund is issued if or when an over payment has been identified. If you feel a refund is due, please contact our office. *

☐ I understand

Please submit your digital signature below.

Name of Patient: *

Name of Guardian (if applicable):

Today's date: *