**Patient Financial Responsibility Agreement**

**Payment Responsibility:** I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. It is my responsibility to confirm coverage provided by my insurance company or other provider.

**Charges for Additional Services:** I understand that charges will be added to my account for other professional services rendered. These charges will be in increments of 15 minutes, or by encounter. Other professional services include extended contact via email, consulting with other professionals (with my permission), preparation of records or treatment summaries, and time spent performing any other service I may request.

**Appointments & Cancellations:** I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment. New Hope Recovery and Behavioral Services may make exceptions and waive the fee, at its discretion, for emergency or unusual circumstances. I understand that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may result in termination of therapy. If my therapist or physician needs to cancel my appointment for an emergency, New Hope Recovery and Behavioral Services will make every effort to reschedule me/my family in an appropriate time frame at no charge.

**Returned Check Fee:** I understand that a fee of $35.00 will be added to my account for any check returned by my financial institution regardless of reason. Should a check be returned, I will not be permitted to write a check again for a period of 6 months.

**Delinquent Accounts:** I understand that my account may be turned over for collection and I will be responsible for all costs of collection monies owed, including court costs, collection, and attorney fees. If I fail to make any payments for which I am responsible in a timely manner, I may be charged a 1.5% service charge monthly on the remaining balance.

I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

**Patient Name:** Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_\_\_

**Patient/Parent/Guardian Signature:**

**Printed Name:**

**Date:**