ORCHARD PLACE
PREADMISSION FINANCIAL AGREEMENT

ORCHARD PLACE CAMPUS

Name of Person Receiving Services: _____

For the services provided by Orchard Place, I understand and agree that I and/or my insurance carrier will be billed. My insurance carrier will be billed at full fee. I understand that Medicaid is always the payer of last resort. **I agree to notify Orchard Place if there is a change in my insurance coverage and understand I may be responsible for all charges if I do not do so.** I understand I am responsible for payment of my fee regardless of insurance coverage and agree to pay my portion of the fee as the service is provided. I understand my payment will be used to cover my co-payment and any charges deemed uncovered by my insurance carrier. I understand that if my account is not paid in a timely manner, the balance may be turned over to a collection agency and court action may be pursued. I understand that payment beyond the full service charge will be returned to me.

I authorize the release of any medical or other information necessary to process insurance claims. I authorize insurance payment of medical benefits and major medical benefits to Orchard Place. I also request payment of government benefits to the party who accepts assignment. A photocopy of this assignment is considered as valid as an original. In addition, if the insurance company issues a check directly to you for services provided by Orchard Place, our psychiatric consultant or pharmacy, this check must be forwarded to our business office to be credited to your account.

FOR UPDATES ONLY: Please provide a copy of your insurance card. Also, indicate whether your insurance has changed. Yes No

The Department of Human Services will make a determination as to how much of the income from sources such as child support, Supplementary/Social Security, subsidized adoption proceeds or trust funds is to be paid towards the treatment expenses of the child. Orchard Place/Campus will be notified of the amount and will send the parent/guardian a statement for the monthly amount due. To estimate the amount of client participation you will owe each month, please provide the following information:

Does this child receive Social Security or Supplemental Security? Yes No If **yes**, how much per month? _____

Does this child receive any child support or subsidized adoption? Yes No If **yes**, how much per month? _____

In order for admission to occur, you will be required to pay the first month of client participation listed above on or before the day of admission. While your child is in treatment, you will be required to pay the client participation amount determined by the Department of Human Services each month.

The Department of Human Services calculates parental financial responsibility for the first month of admission based on parental income. Our full private pay rate is $425 per day; however, if Medicaid deems your child ineligible for the first month of treatment, we will reduce the rate you are required to pay for that month to $209 per day. During the first month, you will also be responsible to pay co-pays, co-insurance and deductible fees based on your private insurance policy benefits.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Your signature indicates that you have read and understand the above and agree to pay Orchard Place the amount of client participation and insurance co-pay if either should be assessed to you.

Signature: _____ Date: _____

Name: _____

Street Address: _____

City: _____ Zip Code: _____

WITNESS SIGNATURE

I have reviewed information and verified understanding with the above signed.

Signature: _____ Date: _____