Medicaid Number: _____ Record Number: _____

Client Name: _____ Date of Birth: _____

FINANCIAL AGREEMENT

Agreement to Pay: Payment for service is due at the time service is provided. I agree to pay the established fee on each visit. I understand that I may be denied an appointment if I refuse to pay. It is my responsibility to inform DAYMARK Recovery Services of any changes that affect my ability to pay. I understand that if I am unable to pay, I may bring this concern to the attention of Daymark and ask for additional sliding scale fee.

Daymark may accept assignment of insurance benefits if we are contracted with your insurance company. However, you must understand:

1. Your insurance policy is a contract between you, your employer (if appropriate), and the insurance company. Our relationship is with you, not your insurance company.
2. We file insurance as a courtesy and it is your responsibility to verify insurance benefits. All charges are your responsibility whether your insurance company pays or not.
3. Should any medical or dental services become necessary while under the care of DAYMARK Recovery Services, requiring you to receive treatment from another facility, you or your legally responsible person are fully responsible for ALL FEES/CHARGES incurred for services you receive (for example ambulance bill, hospital bill, urgent care bill, radiology bill, etc.) I understand that I may be billed separately by any lab provider.
4. I understand that I may be billed separately by any lab provider.
5. If the insurance company does not pay your balance in 45 days, we ask that you contact the carrier.
6. If the insurance company does not pay within 60 days, we ask that you pay the balance due.

Self-Pay Agreement:

There is no guarantee services will be delivered by an in network provider to an insurance plan. Should this occur, you agree to pay a discounted fee rather than being charged full fee for those services. However; please note, those services will not be billed to your insurance plan nor be applied to your deductible or your total out of pocket expenses.

Assignment of Benefits: I authorize and direct all insurance carriers on file and the state Managed Care Organizations (MCOs) who have responsibility for payment of services to directly pay DAYMARK Recovery Services. I authorize and direct any person or corporation having notice of this assignment to directly pay DAYMARK Recovery Services all medical, liability or other insurance or third party benefits. I understand that I am financially responsible to DAYMARK Recovery Services for charges applied to the insurance deductible and for all charges not paid by the insurance company.

Urine Drug Screen Fee (UDS) amount $_10* *May vary based on your insurance and recommended treatment
If you have Medicaid, your fee will be $_0_

A $25 service fee will be charged for returned checks. Returned check charges should be paid by cash or money order within 48 hours of notification.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any problems so that we can assist you in the management of your account.

_____ _____

Signature of Client Date

_____ _____

Signature of Legally Responsible Person Date

_____ _____

Signature of Witness (*Required only when Signature is 'X', mark or symbol* Date

Financial Agreement Rev. 06/14/2023