Financial Responsibility Agreement

Thank you for choosing True North. This Agreement sets forth your financial obligations for all services your child receives from True North including services provided today and in the future. Please initial all lines, sign and date.

Payment Responsibility:

_____The patient (or patient's guardian, if a minor) is ultimately responsible for payment of treatment.
_____I understand and agree I will be financially responsible for all charges for services not paid by insurance.
_____Payment is due 30 days from receipt of statement.

Insurance Billing:

_____I understand and agree it is my responsibility and not the responsibility of the Counselor or True North to know if my insurance will pay for treatment. Although we will verify benefits and coverage, we cannot determine the manner in which your insurance policy will process the claim.
_____I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit or any other type of benefit limitation for services received, and I agree to make full payment.
_____I understand and agree it is my responsibility to know if True North is a contracted in-network provider recognized by my insurance company or plan. If my insurance company or plan does not recognize True North, it may result in claims denial or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
_____I understand that if I am using an insurance plan, the insurance company does not guarantee payment. I understand I am responsible to pay my insurance deductible, copayments, and coinsurance, in addition to payment for any services not covered by my insurance.
_____If I receive any insurance payments directly from my insurance carrier for services, I will immediately (no later than 5 days) forward/pay over such payments to True North.
_____I am required to provide current and correct information regarding my insurance and will be responsible for any charges incurred if the information provided in not correct or updated.

Returned Check Fee:

_____I agree to pay a fee of $25.00 for any check returned by my financial institution regardless of reason.
_____Additionally before further services can be rendered, I will be responsible to pay the balance in full.

Delinquent Accounts:

_____I understand my account, if delinquent, may be referred for collection.
_____I will be responsible for all costs of collection monies owed, including court costs, collection, and attorney fees.

I acknowledge and agree I understand the terms of this Agreement and that True North has answered all questions regarding your obligations under this Agreement.

Client name:_____

Account:_____

Responsible party (printed name):_____

Responsible party (signature):_____

Date:_____