Eating Disorders Treatment Center, LLC

Financial Responsibility Contract

A sincere commitment to one's recovery is necessary to help ensure a positive therapeutic experience while at the Eating Disorders Treatment Center. That sincere commitment is demonstrated not just by putting as much energy and focus as possible into one's recovery, but also by responsible behavior with regard to attendance at scheduled therapy sessions and payment for EDTC services.

EDTC will file insurance claims on the patient's behalf (or for the financially responsible party). However, the client (or the financially responsible party) is responsible for all co-payments or co-insurance payments, deductibles, and any outstanding balance due in the event there is no insurance coverage, insurance disputes, insurance denials, etc. **Please note: that insurance claims cannot be submitted to the carrier in the event of a missed appointment, and payment for any and all missed appointments is solely the responsibility of the client (or the financially responsible party).**

My initials on each line and signature below confirms that I have read, understand, and agree with the following statements.

____ I have been informed of the EDTC fee for services I require, and that it is my responsibility to contact my insurance provider to learn what my expected co-payment or co-insurance is under my policy, and the amount of any insurance deductible remaining on my account (if any).

____ I understand that if I provide my insurance information to EDTC, EDTC will bill my insurance provider on my behalf for services provided, and apply due diligence to obtain payment for billed services.

____ I understand that I am responsible for any and all insurance policy deductibles and that I need to make the full payment towards the deductible for services provided until my deductible is met.

____ I understand that it is my responsibility to make any co-payment or co-insurance payment under my policy to EDTC at the time services are rendered unless other arrangements have been made in advance and approved in writing with EDTC.

____ I understand that it is my responsibility to render payment in full to EDTC for services provided should EDTC be unable to obtain payment in full from my insurance provider within 45 days of the date of service.

____ I understand that should my account balance exceed $100.00 or 30 days past due, EDTC will charge my credit card on file for the amount due as per my "Credit Card on File Agreement".

____ I understand that after 45 days from date of service, it is my responsibility to attempt to recoup from my insurance provider any payments I have made to EDTC to cover balances due.

____I understand that payment to EDTC for services provided may be made with check, cash, MasterCard or Visa, (including insurance issued Visa/MasterCard benefit cards).

____ **Collection and Attorney Fees and Costs:** In any action incurred to enforce this contract or defend services provided according to this contract, the client will be responsible for any additional fees added as a result of an outside collection agency or any reasonable attorney fees.

Financial questions should be directed to, or special arrangements for payment should be discussed with the EDTC Billing Manager, Gloria Gordon. She can be reached at 505-266-6121 ext. 121.

Client Signature _____ Date _____

Financially Responsible Party (Print) _____

Signature _____ Date _____