



109 Legion Avenue New Haven, CT 06519. Phone 203-562-2264 Fax 203-401-4298
www.continuumct.com & www.continuumcrisisrecovery.com

FINANCIAL AGREEMENT

Client Name: _____ D.O.B: _____ Start of Care Date: _____

Program: _____

Payer: _____ ID #: _____

THIS FINANCIAL AGREEMENT sets forth the financial obligations of the client or other person who has agreed to pay for services delivered by Continuum of Care, Inc. (COC). The client or other person who has agreed to pay for services to the client is referred to in this Financial Agreement as the "Financial Sponsor".

Continuum of Care, Inc. (COC) whose Administrative office site is located at 109 Legion Avenue, New Haven CT 06519 will assist the client/financial sponsor in determining if in-network and/or out-of-network benefits are available. The financial sponsor shall be responsible for any out of-pocket costs including but not limited to deductible, co-pay, co-insurance, and any clinically denied services. If pre-determined costs are identified with in-network or out-of-network benefits, then payment is expected at the beginning of each appointment or prior to admission into COC programs. Accepted forms of payment include cash, check, or credit card. If no out-of-network benefits are available and a Single Case Agreement cannot be obtained, then the financial sponsor assumes the full financial responsibility for services rendered. **This means that the Financial Sponsor is responsible for all costs for services provided to the client that are not covered by their insurance benefits.** COC will clearly explain and outline all costs in these situations. I, the Financial Sponsor, hereby acknowledge the rates of services on the attached addendum and individually agree to guarantee the payment for all services rendered by COC to the client.

I hereby acknowledge my deductible/coinsurance/copay of \$_____ to COC, which I understand will be applied to my out-of-pocket expenses. Out-of-pocket expenses include ALL service fees if health insurance reimbursement is available.

For recipients receiving Medicare benefits, COC is required to provide you with an Advance Beneficiary Notice which includes any services that are unlikely to be covered.

In residential/crisis stabilization cases (such as Luna's Path programming), COC will provide you with notice for any services that are unlikely to be covered by the insurance provider.

I understand that I will likely receive correspondence from my insurer regarding services COC has delivered and that I must forward any and all such correspondence including payments, explanations of benefits, denials, etc. that I receive from my insurer to COC. **I acknowledge and understand that cashing a check from the insurance provider that was intended to be a payment for services rendered by COC can be considered fraudulent.**

I understand that failure to provide all necessary insurance correspondence to COC will result in me being liable for the full payment of any and all services rendered by COC, notwithstanding any insurance reimbursement to which the client or COC may have been entitled.

I understand that services may be denied to the client if there is an overdue balance. I understand that if the overdue account is not paid according to the terms of this Financial Agreement, the account could be referred to a collection agency or legal action may be taken against me. COC may pursue all avenues of collection, including use of collection agencies.



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I also understand that should any such collection or legal action be initiated concerning this Financial Agreement, I will be fully responsible for any and all attorney fees and other reasonable costs associated with collecting payment on this account.

Payment for services is due at the time of the service, unless alternative billing arrangements have been approved and can be made in cash, check or charge (MasterCard, Visa, AMEX or Discover). In the event payment is not made at the time of service, payment is due upon receipt of the billing invoice and payment must be received no later than 30 days after the date of invoice. In addition, COC may charge your credit card for amounts past due in accordance with your credit card pre-authorization form.

Cancellation & Termination

Please note that consistent attendance and participation with scheduled treatment & programming is essential in providing the highest and most consistent level of care to each individual. Clients who frequently miss or do not show for their scheduled appointments create administrative and clinical difficulties, missed business opportunities for the Agency, and may not lead to the client receiving effective treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as an inability for Continuum and the client to effectively follow a treatment plan.

Self-Pay Fees (Service @ rate): _____

Financial Sponsor (Print) _____

Financial Sponsor (Sign) _____ Date _____

If the Financial Sponsor is not the client, please indicate relationship to the client: _____

Continuum Finance Representative (Print) _____

Continuum Finance Representative (Sign) _____ Date _____