FINANCIAL AND SERVICE AGREEMENT

PATIENT NAME (PRINT)____

I do hereby agree to pay Christian Health Care Counseling Center (CHCC) the full and entire amount of any and all costs for treatment or other services related to my care or that of my dependant.

I understand that CHCCC cannot guarantee that my hospital/medical insurance coverage will be adequate to pay for all services rendered by CHCCC. I also understand that I am responsible for complying with my insurer's requirements regarding my coverage. If my insurer denies coverage, I agree to be responsible to CHCCC for payment of all bills related to my care. I will be responsible to pay the balance of any bills not paid by insurance in accordance with CHCCC's standard billing terms, which require payment in full of all charges billed by the 20th day of the month following the month in which bills occurred. I agree to make payments of co-pay or set fees at time of each visit.

I understand that if I cancel an appointment less than 24hours in advance or do not show for an appointment, I may be charged $25 fee, which may not be covered for by my insurance.

I understand that failure to make payment in accordance with this agreement will result in the assessment of finance charges at the rates of 1 ½ percent per month on unpaid balances, which I will be responsible to pay. Should it be necessary for CHCCC to engage an attorney or collection agency for the purpose of collecting such unpaid balances, I agree to pay for any and all related costs and fees. This consent will expire at the time that I no longer have any unpaid balances to CHCCC.

I hereby authorize CHCCC to release any medical information acquired in the course of my examination or treatment which may be needed to process a claim for medical insurance benefits.

Any violation of the terms of this contract shall be just cause for the termination of CHCCC's obligation to provide further services to me. Based upon such violations, I may be referred to another provider.

Assignment of Benefit: I hereby authorize payment directly to CHCCC of the insurance benefits otherwise payable to me, but not to exceed the balance due of CHCCC's regular charges for these periods of services. I agree to remit to CHCCC any payment directly to me for these services to be applied to my outstand balance until paid in full.

Guarantee of Payment: In order for CHCCC to enter into a Financial and Service Agreement (the "agreement") with ____________________________ (the "client") the undersigned ("client/guardian") hereby guarantees compliance with regulations dictated by the insurance carrier, including but not limited to the payment of copayments, deductibles, and non-covered charges. If the client/guardian fails to notify CHCCC of a change in insurance coverage, the client/guardian will be held responsible for the resulting balance due. This agreement is unlimited, continuing, and absolute with respect to each of the terms and conditions and obligations of the client under that agreement. The client/guardian agrees that the institution may proceed to bill and/or collect pay for services rendered. I have read and understand the Financial and Service Agreement.

________________________ ________________ ___________________________

Client/parent/guardian **Date** **Staff Witness**

REFUSAL TO SIGN THIS FORM WILL RENDER THE CLIENT RESPONSIBLE FOR PAYMENT

_______________________ ________________

Authorized Personnel **Date**