

FINANCIAL RESPONSIBILITY AGREEMENT

By signing this agreement, I acknowledge that I am the financially responsible party for the client at Child & Family Agency of Southeastern Connecticut, Inc (CFA). This agreement applies to clients who: have HUSKY, commercial or military insurance, do not have insurance (self-pay), or choose not to use insurance for CFA services (private pay).

Understanding Insurance Costs

At CFA, we understand that healthcare insurance can be hard to understand and at times confusing. The information below confirms terms and ensures we have a common understanding of insurance terms:

- **Co-payment:** a fixed dollar amount you pay directly to the service providers for a health care visit.
- **Deductible:** a set dollar amount you pay yourself for care before insurance starts paying.
- **Co-insurance:** a split percentage of the bill (such as 20% for you and 80% for the plan) that you pay after you meet your deductible.
- **Statement:** CFA will send a monthly statement detailing any balances owed.

General Responsibilities

I agree to:

- Provide current insurance information that confirms the client's eligibility to receive services. Should changes in insurance occur, new insurance information must be shared with CFA by the time of the client's next appointment.
- Complete any additional paperwork or forms required by my insurance company to receive prior authorization for client services.
- Inform the client's provider if they are receiving similar services from another provider that could be duplicate services provided by CFA. This is important as it could create a situation where the insurance will not pay for one of the services.
- Contact the CFA billing department if I have questions about insurance coverage, billing, payment arrangements, or financial assistance.

Payment Responsibilities

If applicable, I agree to:

- Pay any insurance co-payment (co-pay) prior to or at the time of the visit.
- Pay any deductible or co-insurance that remains after my insurance has processed the claim.
- Pay the full cost of services if I do not have insurance or choose not to use my insurance per the fee schedule that follows.

Outstanding Balances

I understand that:

- If the client transitions from one CFA service to another, any outstanding balance must be paid in full prior to starting the new service.

- If client withdraws from a program with an outstanding balance, I remain accountable for paying the balance.
- Failure to meet financial responsibilities may affect client's ability to schedule future appointments and could result in discontinuation of services.

Fee Schedule

For those clients with commercial or military insurance, CFA has either negotiated or accepted the rates set by your insurance company and will be disclosed on your explanation of benefits (EOB) or your monthly CFA billing statement.

The fee schedule below includes our base fee applicable for private pay or self-pay clients. Based on specific services rendered during sessions, these could vary based on time spent.

Program	Intake Session & Case Management	Follow-Up Sessions or Med Check
Child Guidance Clinic (CGC) / Outpatient Therapy	\$150	\$120
Functional Family Therapy (FFT)	\$180	-
Multi-dimensional Family Therapy (MDFT)	\$180	-
Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)	\$180	-
Adult Outpatient Therapy (AOT)	\$150	\$120
Urgent Crisis Center (UCC)	\$1000	-
Psychiatry (Psych)	\$275	\$125-\$175

Clients participating in the following CFA services will not be billed for out of pocket fees:

Grant Funded Programs	Intake Session	Follow-Up Sessions
Intensive Family Preservation (IFP)	N/A	N/A
Reunification & Therapeutic Family Time (RTFT)	N/A	N/A
Family Resource Centers (FRC)	N/A	N/A
Youth Engagement Partnership (YEP)	N/A	N/A
Healthy Futures (HF)	N/A	N/A
Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS) ^Some insurances	*	*
School Based Health Centers- Medical & Mental Health (SBHC)	*	*
Intimate Partner Violence - Family Assessment Intervention Response (IPV-FAIR)	*	*

** Note: CFA will make a Good Faith Effort to obtain and confirm insurance eligibility to bill insurance for these programs*

Financial Assistance

If I am unable to pay my balance, I understand that I may contact CFA's billing department by calling (860) 437-4550 Option 5 to discuss available payment options or determine whether I qualify for a reduced fee. To determine whether I qualify for financial assistance, CFA may ask me to:

- Provide updated financial information
- Share documentation of hardship
- Agree to a specific payment arrangement

Release of Information: I authorize CFA to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

Assignment of Benefits: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

Medicare Authorization: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Financially Responsible Party Signature

Client (if over 18 years old) or Parent/Legal Guardian

Date (MM/DD/YYYY):

Printed Name (First & Last):

Signature:
