Easterseals Capital Region & Eastern Connecticut

Medical Services & Administration • *100 Deerfield Rd., Windsor, CT 06095* • *860-270-0600*
Vocational & Veterans Services • *22 Prestige Park Circle, East Hartford, CT 06108* • *860-728-1061*
Veterans & Adult Day Services • *24 Stott Avenue, Norwich, CT 06360* • *860-859-4148*

Service and Fee Agreement

Name: DOB: Date:

I understand and agree that I am financially and legally responsible for full payment of my bills and that any failure of my insurance carrier/payor to pay for all or any part of my bill does not constitute a reason for me to refuse to pay. I understand that my insurance policy is a contract between myself and the insurance carrier/payor and that Easterseals Capital Region & Eastern Connecticut is not responsible for settling disputed claims. I understand that claims are submitted directly to my insurance carrier/payor and I will receive a statement each month if my account has not been paid in full. I further agree, in the event that my bill is referred for collection after a default, to pay for all costs of collection including court costs and reasonable legal fees. I understand that I am responsible for notifying Easterseals Capital Region & Eastern Connecticut should my insurance carrier change while I am receiving treatment.

CONSENT TO RELEASE INFORMATION: Easterseals Capital Region & Eastern Connecticut has my permission to release the necessary protected health information regarding my services to my insurance carrier/payor in order to facilitate payment for services.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits payable through my insurance carrier/payor to Easterseals Capital Region & Eastern Connecticut for services provided. This agreement shall be in effect for the duration of treatment.

PRIMARY INSURER: ID#:

SECONDARY INSURER: ID#:

SERVICES TO BE PROVIDED:

BENEFIT VERIFICATION: **If you have Medicare**: Medicare does not verify benefits or coverage prior to claim submission. Medicare pays 80% of allowable covered services; 20% is your responsibility. Medicare also has a deductible of $183 annually (2018). Easterseals will bill your secondary insurer for the 20% coinsurance and the $183 deductible. You are responsible for any balance not covered by the secondary insurer. **For other insurance**: Per phone contact, your insurer has verified the benefits listed below. However, you are urged to contact your insurance to verify your coverage and it is your responsibility to inform us of any change in insurance coverage. **For neuropsychological evaluation patients**: This includes any change in insurance coverage after testing appointments until report is received, as applicable, due to billing for scoring, interpretation, and report writing.

DEDUCTIBLE: CO-PAY:

All patients are responsible for deductibles, co-insurance, and co-pays. Co-pays are due at the time of each visit.

COINSURANCE AND/OR NON-COVERED SERVICES: Your insurance carrier/payor states that verification of coverage is not a guarantee of payment. Any and all coinsurance, non-covered services and/or remaining balances are the responsibility of the patient and all are billable and payable monthly.

CANCELLATIONS: A $25.00 No-Show fee will be billed to you in the event that you do not provide 24-hour notice of cancellation. The $25.00 will be due and payable prior to your next scheduled appointment.

I understand and agree with the policies and information contained in this Service & Fee Agreement.

Print Name	*Print Name
Signature Date	*Address:
	*Phone:
Staff Signature Date	*Signature Date
_____ Copy given to patient.	*Financially responsible person if other than patient.

Medicare Patients Only

Medicare Attestation of Home Health Care Service

Medicare will not pay for outpatient rehabilitation if you are receiving Home Health Care Services. Please read the following and check the appropriate line indicating your current home health care status:

_____ I **am not** receiving home health care services currently.

_____ I **am** currently receiving home health care services.

Home health care agency: _____

Agency phone number: _____

Agency contact: _____

Service start date: _____

_____ I **was** recently discharged from home health care services.

Home health care agency: _____

Agency phone number: _____

Agency contact: _____

Service start date: _____ End Date: _____

Easterseals Capital Region & Eastern Connecticut is not responsible for non-payment of services by Medicare resulting from conflict with or non-disclosure of home health services. You are responsible for any non-payment of services billed by Medicare.

_____

Patient Signature Date