easterseals
Capital Region &
Eastern Connecticut

Service and Fee Agreement

Patient 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 INSURANCE: _____ ID:_____ Deductible: $_____ Co-Pay: $___

SECONDARY INSURANCE: _____ ID:_____ Deductible: $_____ Co-Pay: $___

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 $203 annually (2021). Easterseals will bill your secondary insurer for the 20% coinsurance and the $203 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 above. 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.

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. Any application submitted for the Sliding Scale Discount Program is not a guarantee of participation in the program. Applications must be received and reviewed prior to services being provided. Applicant will be notified of decision.

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* Signature Date

**Financially responsible person if other than patient.*

_____ _____ _____

Staff Name Staff Signature Date

☐ Copy given to patient

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