COMPASS Health

FINANCIAL AGREEMENT

Client Name/DOB/ID *(or affix label)*	Client Insurance: ☐ New ☐ Change Effective Date: _____/_____/_____

❑ **MEDICAID:** ProviderOne # *(example 123456789WA)*:_____

❑ **APPLE MCO PLAN:**

❑ Amerigroup ❑ Community Health Plan of WA ❑ Coordinated Care of WA ❑ Molina Healthcare ❑ United-Optum Healthcare

- I agree to present my insurance eligibility card the first of each month.

❑ **MEDICARE: MBI:** _____ SUPPLEMENTAL INS:_____

- I request payment of authorized MEDICARE benefits be made directly to the agency appointed by me.
- I authorize the holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits payable to related services.
- I understand that I will be responsible for the annual deductible and co-payment not paid by supplemental insurance.
- I understand that fees are based on current MEDICARE allowances.

❑ **COMMERCIAL INSURANCE:** I understand I am responsible for any co-pays and deductibles as defined by my insurance policy. I understand I am responsible for obtaining pre-authorization for services, and that failure to do so may result in the full fee being charged to me.

Primary Commercial Insurance		**Secondary Commercial Insurance**	
Insurance ID#:		Insurance ID#:	
Insurance Company:		Insurance Company:	
Insurance Co. Phone:		Insurance Co. Phone:	
Subscriber Information (if insurance is under someone other than the client):			
Subscriber Name:		Subscriber Name:	
Subscriber Address:		Subscriber Address:	
Relationship to Client:		Relationship to Client:	
Subscriber DOB:		Subscriber DOB:	
Subscriber's SSN #:		Subscriber's SSN #:	
Subscriber's Employer:		Subscriber's Employer:	
Plan or Group #:		Plan or Group #:	

❑ **SELF-PAY/UNINSURED:**

Office use only:

Based on the Sliding Fee Worksheet, fees are set at _____% of the full fee.

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All Clients:

- I authorize release of medical information necessary to process my claim.
- I agree to the assignment of all insurance payments to Compass Health, PO Box 3810, Everett WA 98213. I authorize my insurance carrier to pay benefits directly to the agency. I agree to forward any insurance payments I might receive directly to the agency. **Insurance does not guarantee benefits. I am responsible for fees not covered by insurance.**
- It is my responsibility to inform the agency of any changes in my financial status.
- I understand that my portion of the fee is due at the time of service and agree to pay promptly all fees for which I am responsible; failure to do so may result in termination of services.
- **If I lose Medicaid while in services with Compass Health,** I understand I am fully responsible for all fees incurred, and that income verification may be required.
- A copy of Compass Health's fee schedule is posted at the office and is available upon request. I understand that these fees are subject to change based upon the revision of the fee schedule.
- **I understand that I may be charged a NO-SHOW FEE for missed or canceled appointments unless 24 hours' notice is given.**

I have read and agree to the above conditions. **Unpaid fees are subject to collection.**

Client or Responsible Party Signature | Date

Client or Responsible Party Printed Name

Parent/Legal Guardian Signature | Date

Parent/Legal Guardian Printed Name