Hope Performance Systems LLC
460 William Hilton Pkwy Ste B
Hilton Head Island, SC 29926-2497

Client Financial Policy

Thank you for choosing HOPE PERFORMANCE SYSTEMS as your Behavioral Healthcare Provider. We are honored by your choice and are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our office manager.

The Client (or client's guardian, if a minor) is responsible for the payment for his/her treatment and care. We are pleased to assist you by billing for our contracted insurers. However, the client is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated. Clients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service and for your convenience, we accept Visa, MasterCard, American Express, Discover, cash, and in state checks at our office. With your authorization, we can store a credit card on file and charge any balances at the time of service. We do not allow balances to go unpaid unless a prior arrangement has been approved by the Office Manager on a case-by-case basis. All outstanding balances must be paid prior to your next appointment.

If you are covered by health insurance with MENTAL HEALTH benefits, we will bill your insurance. We require at each visit that a picture ID or driver's license be presented along with your current insurance cards. The front office staff will verify your coverage and eligibility and the expected amount due as a courtesy. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

Due to the various different insurance plans and carriers, it is impossible for us to know all the covered benefits, copays and deductibles for each individual plan. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered or referred by HOPE PERFORMANCE SYSTEMS, on your behalf, are paid in full. By signing below, I am acknowledging that I am personally responsible for all charges incurred regardless of any thirdparty insurance.

Clients may incur and are responsible for the payment of additional charges at the discretion of HOPE PERFORMANCE SYSTEMS. These charges may include (but not limited to) • charges for returned checks • charge for missed appointments without 24-hour notice • charge for the copying and distribution of patient medical records • charge for extensive forms completion. • All costs associated with collection of patient balances.

SELF PAY CLIENTS:
All charges are to be paid at the time of service. We will extend a 25% discount ONLY to all self-pay clients and when the charges are paid in full at the time of service.

UNINSURED CLIENTS:
In the event a client is uninsured and unable to pay for services we will, on a case-by-case basis, offer discounted charges on a sliding scale, based on income. This is at the discretion of the practice Office Manager, the Director of Finance and Billing and/or the CEO.

CANCELLATIONS OR MISSED APPOINTMENTS:
If you do not call and cancel your appointment at least 24 hours before your appointment, or if you do not show for your appointment you can be assessed a $25 no show fee.

DIVORCED PARENTS OF MINOR CLIENTS:
By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby assign, transfer, and release directly to HOPE PERFORMANCE SYSTEMS all insurance benefit payments to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize HOPE PERFORMANCE SYSTEMS to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to HOPE PERFORMANCE SYSTEMS. I authorize HOPE PERFORMANCE SYSTEMS to release all medical information (including, but not limited to, information on psychiatric conditions and alcohol and drug abuse) requested by my health insurance carrier, Medicare, other physicians or providers, and any other thirdparty payers.

RELEASE OF INFORMATION:
I hereby authorize and direct HOPE PERFORMANCE SYSTEMS to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient/Guarantor: _____

Name of the Patient: _____

Date: _____