# PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Connecticut Psychiatric & Wellness Center as your healthcare provider. The services you seek imply a financial responsibility on your part which obligates you to ensure payment in full for the services you receive. To assist in understanding your financial responsibility, we ask that you read and sign this form.

By signing below and/or by receiving medical services from CPWC, you agree:

1. I am ultimately responsible for all payment obligations arising from my treatment or care and guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by my insurance carrier or CPWC Policies, which are not otherwise covered by supplemental insurance.
2. I am responsible for knowing the benefits of my insurance policy. If I am not familiar with my plan coverage, I will contact my carrier or plan provider directly.
3. I will be required to update or verify personal information, present verification of current insurance, provide signatures, and pay any co-pays or other patient responsibility amount at each visit. My card or other insurance verification must be on file for my insurance to be billed. If CPWC does not have my card on file or the service is denied by my insurance, I will be treated as a self-pay patient. As a self-pay patient, the fee is expected to be paid in full at the time of service.
4. I can request a billing statement be emailed to me that contains the total cost of my service(s) or procedure(s) received during your visit(s).
5. I authorize CPWC staff to communicate by email, voicemail messages, and/or text message according to the information provided in your patient registration information.

Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of CPWC's PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to CPWC for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (v) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law). I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original. ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

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Patient/Responsible Party/Guardian Date