Received Clients' Right and Responsibilities: ☐ Yes ☐ No

COMCARE of Sedgwick County

FINANCIAL INFORMATION SHEET

Waiver: ☐ Pending:☐ CONFIDENTIAL Center: _____

Client Name: _____, _____ **Birthdate:** _____ **SS#:** _____

Address: _____ _____ _____ _____ **County:** _____ **Home Phone:** _____

Employer: **Work Phone:** **Responsible party (if other than client):** _____

Insurance (attach copy of Primary insurance card)

Insurance Co: _____

Policy Holder: _____

Insurance Address: _____

Insured's SS # or ID #: _____ **DOB:**

Group # : _____ **Effective Date:** _____

Employer: _____

Healthwave Cert #

Secondary Insurance (attach copy of insurance card)

Insurance Co: _____

Policy Holder: _____

Insurance Address: _____

Insured's SS # or ID #: _____ **DOB:** _____

Group #: _____ **Effective Date:** _____

Employer: _____

Third Insurance: (attach copy of insurance card)

Insurance Co: _____

Policy Holder: _____

Insurance Address: _____

Insured's SS # or ID#: _____ **DOB:** _____

Group #: _____ **Effective Date:** _____

Employer: _____

All patient fees, including co-pays, are due at the time of service. Co-pays will override any sliding fee rates. Our services are billed based on the type and amount of services you receive. Upon presenting proof of total household income, such as check stubs, bank statements, or previous year's tax return you may be eligible for our sliding fee rate. No one will be refused treatment based on their ability to pay.

Total Household Income:

Number of Persons in Household: _____ **% To Pay** _____

$ per intake hour **$** _____ **per injection**

$ _____ **per Individual Therapy Hour** **$** _____ **per Ind Comm Support Hour**

$ _____ **per Group Therapy Hour** **$** _____ **per Psychosocial Therapy Hour**

$ _____ **per Case Management Hour** **$** _____ **per Attendant Care Hour**

$ _____ **per Medication Review** **$** _____ **per Case Conference Hour**

$ _____ **Co-Pay/Other**

$ _____ **Co-Pay/Other**

Extenuating Circumstances:

I hereby authorize COMCARE of Sedgwick County to file my claims with the Insurance companies listed on this financial and for payment from my insurance companies to be made directly to COMCARE of Sedgwick County. I also authorize COMCARE of Sedgwick County to release my initial assessment, any progress notes, results of psychological, psychiatric and/or substance abuse evaluations, medical history, and/or results of any laboratory tests in order to process my claims.

This consent and authorization is subject to a written revocation at any time except to the extent that action has already been taken. This consent will expire on _____ **unless it is expressly revoked by the consumer.**

It is understood that any consumer payment, which results in a credit balance after insurance payment is received will be refunded to me after all charges are paid in full.

Consumer or Responsible Party Signature	**Date Signed by Client**
Witness Signature	**Date**

Please mail payments to:
COMCARE of Sedgwick County
635 N. Main, Wichita, Kansas 67203

Please call 316-660-7610 with any billing questions.

Client Name: _____, _____
22.006 06/1998 rev 01/06

Patient ID#:
Financial Information Sheet

FINANCIAL INFORMATION & OBLIGATIONS

- All patient fees are due in full at the time of service unless credit has been established. Your medical and or insurance may cover all or part of your treatment. All claims sent to insurance companies or Medicare will be billed at COMCARE's full rate. Should your private insurance pay less than 100%, you will be responsible for the balance due based on your sliding fee rate.

- You are obligated to pay full rate for the services you receive if:

    1) You choose not to file with your insurance company
    2) If you fail to get a required referral or pre-certification
    3) If you choose to receive services out of your insurance network
    4) If you fail to provide requested information to your insurance company
    5) If you are not a Sedgwick County resident

- You are obligated to pay your sliding fee rate for the services you receive if:

    1) You do not have insurance
    2) You are receiving services that are not covered by your insurance
    3) Your insurance denies payment due to a pre-existing condition
    4) You have reached your maximum benefit allowed for any one service.

- Medicaid consumers 18 years of age and older who are receiving individual therapy are responsible for a $3.00 co-pay per date of service, which is due at the time of service.

- If you have private insurance, you are responsible for applicable co-pays at time of service.

- Past Due balances will be referred to an outside collection agency unless an alternate payment arrangement has been approved by our credit counselor. The payment plan will apply to past due balances only. New charges must be paid as they are incurred.

- You must notify the COMCARE receptionist if you have any changes in insurance coverage.

I have read and understand my financial obligations as a consumer of COMCARE.

Consumer's Signature	Date
Parent/Legal Guardian's Signature	Date
COMCARE Staff Signature	Date

Please contact the Patient Billing Department with any billing questions: 316-660-7610