COMCARE
Sedgwick County... working for you

Patient Financial and Payment Agreement

Patient Information	Today's Date:
Patient Name:	**Date of Birth:**
Mailing Address:	**SSN:**
City, State, Zip	**Responsible Party:**
Primary Phone & Type:	**Responsible Party SSN:**

PAYMENT MAY BE EXPECTED AT THE TIME OF SERVICE. FEES ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE.

You may qualify for a discount based upon your household income and number of people in household.

Household Information

Annual Household Income:
Number in Household:

Employer:

Receiving SSI/SSDI benefits? ☐ SSI / ☐ SSDI

Payment Method (Check all that apply)

☐ Self-Pay	☐ Private Insurance
☐ Medicaid	☐ Medicare
☐ Voc-Rehab	☐ Railroad Medicare
☐ Blue Cross/Blue Shield	☐ Champus/TriCare
☐ DDS	☐ VA
☐ EAP	☐ Unemployed

Mailing Information, if different than patient's

Name:

Mailing Address:

City, State, Zip

Primary Insurance Carrier

Insurance:

Policy Holder:
Policy Number:

Date of Birth of Policyholder: **Policy Effective Date:**

Secondary Insurance Carrier

Insurance Company:

Policy Holder:

Policy Number:

Date of Birth of Policyholder: **Policy Effective Date:**

Tertiary Insurance Carrier

Insurance Company:

Policy Holder:

Policy Number:

Date of Birth of Policyholder: **Policy Effective Date:**

General Information:
If any of the above information changes, you must inform COMCARE staff immediately so your account can be updated.

Sliding Scale Benefit:
If you have insurance, your insurance will be billed at our usual and customary rates. Depending on your income and number of dependents, COMCARE offers a sliding scale benefit of up to 95% off of our usual and customary rates...

Insurance Information:
Authorization to file claims: I authorize COMCARE of Sedgwick County to file my claims with the insurance companies listed on this document.

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If a delay in furnishing your insurance results in a denial of payment due to filing requirements, you will be responsible for 100% of your service cost. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file the claim for you. **Please notify COMCARE of any changes in your health insurance carrier immediately**. **Failure to do so may result in you being financially responsible for your service costs.**

Outstanding Balance:

If you have an outstanding balance, you are encouraged to contact our billing office to set up a payment arrangement..
NO ONE WILL BE REFUSED TREATMENT BASED ON INABILITY TO PAY.

Your account may be turned over to the Kansas State Set-Off Program for collection due to non-payment. (this means your income tax return).

Release of Information: I assign benefits of my medical insurance contract, Medicaid or Medicare to COMCARE and authorize payment directly to COMCARE. I authorize COMCARE to release medical information to payers as required for payment of claims for medical services.

Authorize Appeals: I authorize COMCARE of Sedgwick County to appeal any claim for service denied by my insurance company on my behalf.

Substance Abuse Service Disclaimer

Substance Abuse Services may not be covered by many insurance companies although current law mandates payment. Therefore, if your insurance company does not reimburse for this type of service, you will be responsible for the full payment based upon our sliding scale fee.

Medicare Beneficiary Disclaimer

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the Medicare program standards, Medicare will deny payment on that service.

Sliding Scale Fee (Out of Pocket)

The sliding scale has been explained to me and I understand that I will be responsible for all charges not covered by my insurance company. The undersigned understands and agrees to the above financial conditions.

Signatures	
Patient Signature: _____	**Date:** _____
Parent/Guardian Signature: _____	**Date:** _____
Witness Signature: _____	**Date:** _____

This financial and payment agreement consent and authorization is subject to written revocation at any time except to the extent that action has already been taken. This consent and authorization will expire one year from signature date unless it is expressly revoked by the patient/guardian.

COMCARE Staff to complete
Your Sliding Scale % is _____.
Additional Information: _____

Clear Form