Zumbro Valley Mental Health Center

Client Financial Agreement

Client Name: _____ County of Residence: _____

	Guarantor Financial Information	*Spouse Financial Information*
Full Name:		
Social Security No.:		
Place of Employment:		
Job Title:		
Income:		

Sliding Fee Scale (Available to Olmsted and Fillmore County residents only): ☐ Proof of income collected

Gross Monthly Household Income $ _____, Number in Household _____ Guarantor Responsibility_____%, County Resp. _____%

Note: Fees are subject to change. Clients utilizing the sliding fee scale are required to notify the ZVMHC Business Office of any change in income or number of people in household, which may affect the client percentage.

Full Fee (other): ☐ Client's insurance company does not assign payment to ZVMHC. ☐ Out of County Resident
☐ Client elects not to share insurance info with ZVMHC.

Primary Payer Company Name			Policy Date Policy Number Group Number
Company Address, City, State, Zip	Phone #		
Policy Holder Name	Policy Holder Employer	Client Relationship to Policy Holder	Insured DOB
Secondary Payer Company Name			Policy Date Policy Number Group Number
Company Address, City, State, Zip	Phone #		
Policy Holder Name	Policy Holder Employer	Client Relationship to Policy Holder	Insured DOB
Tertiary Payer Company Name			Policy Date Policy Number Group Number
Company Address, City, State, Zip	Phone #		
Policy Holder Name	Policy Holder Employer	Client Relationship to Policy Holder	Insured DOB

AUTHORIZATION TO RELEASE INSURANCE INFORMATION - I authorize Zumbro Valley Mental Health Center (ZVMHC) to contact my insurance carriers and other third party payers to exchange all pertinent information concerning coverage and payments made under my policy. I direct ZVMHC, the insurance company or third party payer to exchange such information.

ASSIGNMENT OF BENEFITS - I hereby authorize and request the insurer listed on this form to pay directly to ZVMHC any benefits due under the terms of this policy for services provided by ZVMHC. If my health insurance will not allow direct payment to ZVMHC, I agree to immediately forward to ZVMHC all health insurance payments I receive. I understand that failure to forward the payments to ZVMHC could result in denial of sliding fee scale benefits.

STATEMENT OF FINANCIAL RESPONSIBILITY - I acknowledge I am responsible for all charges for services provided to me including any amount not paid by my insurance plan. This also applies if I am covered by Medicare or any other third party payers. I understand that ZVMHC reserves the right to pursue delinquent accounts through a collection agent and/or by other legal means, in which cases release of client information may by necessary.

TERMINATION OF SERVICE - ZVMHC reserves the right to terminate services on written notice for non-payment of services.

SIGN HERE _____
(Client or Authorized Representative) (Date) (Relationship) (Intake)

White - Business Office **Canary - Medical Records** **Pink - Clients Copy**