Revised 8/27/14
Chart Section: Financial
Form Responsibility: Financial A/R
Paper Color: purple

Catalyst Life Services

RESPONSIBLE PARTY FINANCIAL INFORMATION

Last:_____ **First:**_____ **MI:**_____

Address:_____

City:_____ **State:** _____ **Zip Code:** _____ **County:** _____

Home Phone: _____-_____-_____ **Cell Phone:** _____-_____-_____

SSN: _____/_____/_____ **Date of Birth:** _____/_____/_____ **Gender:** _____

Client Relationship: _____ **Number of Dependents (including yourself):** _____

Advance Directive? YES If yes, request a copy of the directive
NO If no, ask if client needs assistance in obtaining an advance directive

Employer:_____ **Work Phone:** _____-_____-_____

Major Source of Income: **1. _____ 2. _____ 3. _____**

A. Wages/Salary Income
B. Family or Relative
C. Alimony
D. Child Support
E. Savings or Investment
F. Disability Ins/Work Comp
G. Unemployment Comp
H. Retirement Pension
I. Social Security Retirement
J. General Relief/Welfare
K. Aid for Dependent Children
L. Supplemental Security Income (SSI)
M. Social Security Disability Ins (SSDI)
N. Other
P. None

Employment Status: _____

A. Full Time (35 Hrs or More)
B. Part Time (Less than 35 Hrs)
C. Unemployed (Seeking Work)
D. Homemaker
E. Student
F. Retired
G. Disabled
H. Inmate of Institution (Penal)
I. Other
J. Sheltered Employment

To be completed by financial registration

_____**Self Pay** _____**Insurance** **Name:** _____
_____**Medicaid** _____**Secondary Ins.** **Name:** _____
_____**Medicare** _____**Contract** **Name:** _____
_____**Title XX** _____**Other** **Name:** _____

Net Monthly Family Income:_____ **Proof of Income Attached: YES NO**

Client's Percentage of Discount _____% **MACSIS Rider Code (see rate schedule chart)** _____

AOD Release of information signed? YES NO **Date signed:** _____/_____/_____
Disclosure form given to client? YES NO
Authorization for billing signed? YES NO **Date signed:** _____/_____/_____
Consent for treatment signed? YES NO **Date signed:** _____/_____/_____
In crisis at enrollment? YES NO

Release Form for Third Party Billing and Fee Agreement on back

AGENCY RELEASE FORM FOR THIRD PARTY BILLING

I hereby authorize payment directly to The Center for Individual and Family Services, Inc. for any Third Party benefits payable to me; and authorize the release of necessary information, required by Third Party Payors to process their claims. I agree to pay to The Center any Third Party payments that are paid directly to me for services provided by The Center. I understand that all payments made by my Insurance Company to me or The Center, plus my fee is the property of The Center unless the combined amount exceeds the TOTAL charge made by The Center for services to me and/or my family. If the payment exceeds the TOTAL charge, a refund will be issued.

Client Name:_____ Client ID#_____

Client/Parent/Guardian Signature_____ Date:_____
(Parent or Guardian, if client is a minor)

FEE AGREEMENT

I have agreed to pay 100% of the standard fees for services rendered. These services are based on an hourly fee or on per service charge.

I understand that if I have insurance, I am responsible for my deductible and for any services that my insurance company deems non-covered. I understand if I am eligible for financial assistance from the Richland County Mental Health Board my account will reflect the balance of the fee that I am responsible to pay.

I have received a copy of The Center's Financial Policy, which covers insurance billing and self pay fees.

State of Ohio, County of Richland:

Personally appeared before me, the said _____who, having been duly cautioned, deposes and says that the statements made here are complete and true to the best of his/her knowledge and belief.

Signed:_____

Sworn to and subscribed before me this _____day of _____, 20_____

Notary Public_____

Notary Expiration Date_____