Revised 8/20/2019
Chart Section: Financial
Form Responsibility: Financial A/R

Catalyst Life Services
Responsible Party Financial Information

Last: _____ First: _____ MI: _____

Address: _____

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

Hone 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 Group
G. Unemployment Comp
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
O. 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 & Family Services, Inc." for any Third Party benefits payable to me. I also authorize the release of necessary information, required by Third Party Payors to process their claims. I agree to pay to "The Center for Individual & Family Services, Inc." any third Party payments that are paid directly to me for services provided by "The Center for Individual & Family Services, Inc." I understand that all payments made by my Insurance Company to me or to "The Center for Individual & Family Services, Inc." plus my fee are the property of "The Center for Individual & Family Service, Inc." unless the combined amount exceeds the TOTAL charge for the services provided for 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 must sign 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 a fee 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 received a copy of the Financial Policy for "The Center for Individual & Family Services, Inc." This covers insurance billing and self pay fees.

Client/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Back of Responsible Party Financial Information Form