Fee Agreement

Name (please print) _____ DOB _____ MHCD ID #_____

Mental Health Center of Denver (MHCD) is pleased to provide you with our services. This Agreement provides the terms of payment for our services.

GENERAL PAYMENT TERMS

- I understand that I am financially responsible for services, medications or labs received at MHCD according to this Fee Agreement and the terms of my health benefits plan.
- I agree to pay my share of the cost, including copays, coinsurance or deductibles for my services at the time of service as determined under my health benefits plan.
- In the event my benefit plan changes, I will inform MHCD staff.
- In the event that a financial hardship arises that might prevent me from honoring this Fee Agreement I agree to speak with MHCD, ***before*** receiving further services to discuss my options regarding payment.
- I understand that if I fail to pay my bill to MHCD when due, MHCD reserves the right to take collection or other legal action, and that charges for collection will be added to my bill.
- I understand that if I receive any payment directly from Medicare, Medicaid or my insurance carrier for services provided by MHCD, I must give the payment to MHCD. MHCD will refund to me or my insurance carrier any excess payment it receives, as appropriate.
- I authorize MHCD to bill my insurance carrier on my behalf and to receive direct payment for any insurance benefits payable for the services provided by MHCD.
- I authorize MHCD to release to my insurance cariers any information requested by the insurance company

I have read and fully understand this Fee Agreement. The information I have provided to MHCD is true and correct to the best of my knowledge.

Client Signature: _____ Date: _____

Responsible Party Signature: _____