Assumption of Financial Responsibility

I, _____ understand that Santa Barbara Behavioral Health (SBBH) may not be contracted with the insurance company responsible for my behavioral health care or, if contracted, may not receive full payment from my insurance company. Should the services I receive through SBBH not be covered or fully covered by my insurance, I accept financial responsibility for the full fee for the services I receive.

I understand that I will be responsible for payment of the full private pay charges if I do not have any health coverage in effect with a plan that is contracted with SBBH at the time I receive services from SBBH.

If my insurance company is contracted with SBBH, I understand that I will be responsible to pay any copayment, coinsurance or deductible per the requirements of my health insurance plan's contract with me and my plan's contract with SBBH.

I hereby authorize Santa Barbara Behavioral Health to charge through my credit card for any uncovered services, and understand that SBBH will then reimburse me for any payments subsequently received by SBBH from any third party payer. This authorization will expire six months from today's date.

_____ _____

Patient name Insurance carrier name

Type of Card (Circle one): Visa MasterCard Discover

Credit Card Number: _____

Expiration Date: _____Security code (back of card): _____

Name of Cardholder: _____

Credit Card billing address: _____

_____ Zip_____

Phone number: _____

Authorized Signature of Cardholder: _____

Date: _____

OFFICE USE ONLY

Date of AFR:_____ AFR Expires: (6 months later)_____

Client ID:_____ Noted in system?: Y N Employee Initials:_____