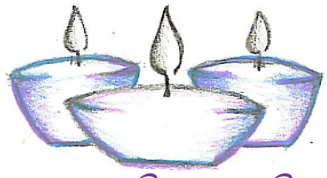
Extrordinary Counseling



"Your Lights to the future."

Financial Agreement

Assignment of Insurance Benefits:

- I authorize the payment of insurance benefits from my third party insurance provider to **Extrordinary Counseling** for all covered services provided by **Extrordinary Counseling**. **I irrevocably transfer and assign to the above provider all right, title and interest in any payments due from all sources for services received.**
- I have been informed that my third-party insurance may be considered "out-of-network" for **Extrordinary Counseling** and therefore may not offer benefits to another provider that is "in-network" **Extrordinary Counseling** will assist me in accessing services from an "in-network" provider. I have been informed that under these circumstances I may choose to access services from **Extrordinary Counseling** only if I pay 100% of the standard charge.

Notification to Medicare Beneficiaries of Liability for Non-Covered Services:

- Medicare will only pay for services that it determines to be reasonable and medically necessary under Section 1862 (a) (1) of the Medicare law. If Medicare determine that a particular service, although it would otherwise be covered, is "not reasonable or necessary" under Medicare program standards, or a service is not a covered benefit of the Medicare program, then Medicare will deny payment for that service. Medicare is likely to deny payment for case management services, mental retardation diagnostic and evaluation services, and some physician, therapy, counseling and ancillary services for the reasons expressed above. I have been notified by **Extrordinary Counseling** that this provider believes that Medicare is likely to deny payment for the services identified above for the reasons stated.

- **If Medicare denies payment, I agree to be personally and fully responsible for payment based upon my ability to pay.** I have been informed and understand that there may be services provided to me that my third-party insurance provider will not cover as a benefit and therefore will not pay. **I understand that I am financially responsible for payment of those services that are not covered according up to my monthly Maximum Fee as determined by my Financial Assessment.**

- I understand that intentionally providing inaccurate or false information or failure to answer truthfully may result in financial and/or other penalties. Penalties may include but are not limited to payback or any funds awarded by the **SSA** and/or **Extraordinary Counseling.**

The information stated on all pages of this financial assessment form is true and correct to the best of my knowledge. I understand that if I do not agree with the results of this Financial Assessment Eligibility Screening I may appeal the results by contacting SAID provider in writing your complaint or consult your insurance provider.

- € I choose not to provide financial information. I understand that I will be charged at a rate of 100%.

- € Financial Agreement

zmb/2011

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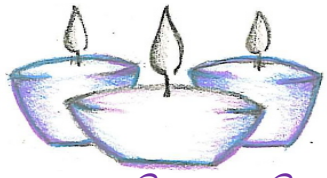

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Regular attendance is crucial to the service provision. If I miss appointments, Extrordinary Counseling policy requires that my case be reviewed for **possible suspension of treatment and payment ($25.00)** due to no cancellation.

_____ (Initial) I am NOT currently insured for these services and would like to be charged the sliding scale rate.

_____ (Initial) My sliding scale fee will be $_____ per session for **Intake /Individual/Couple/Family Counseling** and/or$_____ per hour for **Group (class/counseling).**

_____ (Initial) I authorize Extrordinary Counseling to place a claim for services with my **Insurance carrier** _____ **ID/Policy#** _____, and to release to that carrier any service recipient information necessary to process all claims. I assign all benefits for all claims to Extrordinary Counseling

_____ (Initial) I understand that there is **NO FEE** for services I will receive.

_____ _____

Client/Guardian Signature ***Date***

zmb/2011