FORTIS
BEHAVIORAL HEALTH

Fortis Behavioral Health
220 Wintergreen Drive, Suite C
Lumberton, North Carolina, US - 28358-7502

Consent Form- Payment Authorization

Assignment of Benefits / Financial Responsibility

I acknowledge the payment and insurance information set forth below and agree to pay for services rendered to me.

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I understand that:

-Payment for sessions with providers affiliated with Fortis Behavioral Health is payable through debit or credit card.

-Payment for sessions is due after each session unless otherwise agreed upon and Fortis Behavioral Health will charge my card for my responsibility. Receipts may be provided at the time of the charge or upon request.

-I understand that I cannot submit bills for cancellations to my insurance company or managed care plan.

2. Insurance and Managed Care Plans:

-Fortis Behavioral Health participates in a number of insurance and managed care plans. If Fortis Behavioral Health participates in my plan, I agree to pay all applicable deductibles, co-payments, co-insurances and any other form of cost-sharing. If my insurance benefits run out, Fortis Behavioral Health will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage. If my insurance plan denies the visit despite Fortis Behavioral Health following necessary procedures, I understand I may be responsible to pay in full for the service.

3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care:

-I agree to allow my insurance plan or managed care plan to pay Practice directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Fortis Behavioral Health unless I have already paid the charges myself. I authorize Practice to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Fortis Behavioral Health to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

4. Restricted Service:

- I understand that all account balances must be in good standing prior to receiving additional services and will contact Fortis Behavioral Health's staff if I am unable to pay the balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection, along
with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice.

5. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

6. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.

7. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.

8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date.

9. I will not be provided with advance notice of payments authorized hereunder for transactions up to an amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file and I may request them.

10. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file and my patient portal. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a
mailed copy of any electronic statement.

11. This authorization will remain in effect until I provide written notice of cancellation to the practice.
Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

PATIENT OR PARENT/GAURDIAN SIGNATURE: *

NAME OF SIGNER: *

RELATIONSHIP TO PATIENT (IF SELF PUT SELF): *

Date: *