COMMUNITY DIAGNOSTIC AND TREATMENT CENTER
Financial Agreement

Center# _____ Date 4-4-95

Patient Name Bounds Jacquetta T D.O.B. 3-6-52

Guarantor Name _____ Relationship To Patient _____

Patient Address 1512 Chapel St. 2nd Fl. 45206 Phone 961-0871

Guarantor Address _____

Income(s) Patient or Guarantor Unemployed Spouse _____

Primary Insurance Carrier None Contract ID# _____ Effective Date _____

Secondary Insurance Carrier _____ Contract ID# _____ Effective Date _____

Medicare# _____ Medicaid# Yes Patient Medicaid Recipient# _____

Case Manager _____ Program Center _____ Payor Codes: 1. ~~C~~ C. 2. _____

Attending Physician _____ Patient Fee(%) 0% 3. _____ 4. _____

FEES ARE BASED UPON THE INFORMATION PROVIDED. I AGREE ANY CHANGE OF INCOME WHILE RECEIVING SERVICES WILL BE COMMUNICATED TO THE PATIENT ACCOUNTS OFFICE.

Cost of Service. . . . . $ 75.00 /Hour

Adjustments Estimated Primary Insurance or Medicare $ _____

Estimated Seconary Insurance $ _____

Total Estimated Insurance . . . . . $ _____

Medicaid or Medicaid HMO . . . . . $ _____

Number in Family Three Total Family Income $ 279 /per monthly

Estimated amount provided by Hamilton County Mental Health Tax Levy Funds, and/or the University of Cincinnati . . . $ _____

Total Estimated Adjustments. . . . . $ _____ /Hour

Balance Due to Patient/Guarantor . . . . . $ 0.00 /Hour

SMD Monthly / Yearly (Indicate one) Maximum Financial Cap. . . . . $ 0.00

Patient currently enrolled at other mental health facility? ____ yes X no
If yes, where _____ Date of enrollment _____

Charges non-billable to insurance carrier(s) and Medicaid will be billable to patient/guarantor (telephone therapy and/or missed appointments) at an hourly rate . . . $ 0.00 /Hour

Financial Agreement is pending _____.

X _____ 4-4-95 PF

Signature of Agreement Date Financial Interviewer

Please review back of agreement for Account Information.
White Copy - Account Office Yellow Copy - Patient File Pink Copy - To Patient