WATERSTONE
Addiction & Recovery Services
A Division of Waterstone Health
190 Whitney Ave, Hamden | 32 Wall St, Madison | 400 Bayonet St, New Londo

Patient Financial Agreement with Waterstone Health

PLEASE READ THOROUGHLY AND SIGN.

Waterstone Health is committed to serving our patients with professionalism, care, and concern. We ensure commitment to our patient's treatment, but also expect commitment from our patients including fiscal responsibility. This includes providing current and accurate insurance information and making copay payments at the time of each in-person or telehealth session for privately insured patients.

Any privately insured (non- Medicaid) patient that is found to have an unmet deductible will be assessed a $25 payment per provider until we see deductible information from their insurer. At that time, the patient will be made aware of any additional balance that is owed. During the establishment of new services, patients will be made aware of their fiscal responsibility based on their insurance information or self-pay status if not insured, or not covered by a carrier we take (Out of Network).

If a patient should be unable to pay their co pay or any accumulated deductible balance at time of service, they will be required to *settle all balances due prior to being able to book additional appointments.*
We understand that extraordinary circumstances can occur. When a financial change occurs for the patient, the patient is required to alert the Billing Coordinator immediately by contacting 203-245-0412 ext. 104.

PATIENT FINANCIAL RESPONSIBILITIES

1. Provide Waterstone with ALL current insurance policies including any secondary policies.
2. If you have a change of demographic information, please contact our office with new information for our records.
3. Out-of-network or self-pay patients will be expected to pay for services at time of check-in.
4. Expect that we will collect your co-pay, self-payment, deductible, or coinsurance balance that has accumulated at the time of your visit. It is the patient's responsibility to know the terms of their insurance plan.
5. You must alert us to any changes in your insurance carrier information or ability to maintain payment requirements immediately.
6. You will be responsible for all allowable charges not paid by your insurance company in accordance with the law.
7. Collection services may be used to collect outstanding debts on your behalf.
8. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance for such calls, but if it is not covered by your plan, you may be responsible for the charges.

9. Some insurance carriers require prior authorization. Authorizations must be obtained before your scheduled visit. It is the patient's responsibility to make sure we have received authorization. If you do not have the proper authorization, your appointment will be
10. Self-Pay Patients: SELF-PAY PATIENTS: This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for services is required prior to services being rendered.
11. Receipts will be provided for all services and patients may request their balance information at any time. Any billing questions can be addressed by calling 203-245-0412 ext. 104.
12. Billing statements are sent out monthly and expect to be paid timely.
13. Should you need to cancel or change your office visit appointment, please do so with 24-hours business day advanced notice.

I have read and understand Waterstone Health financial policy, and I accept responsibility for the timely payment of any fees associated with my care. I understand that my services may be involuntarily reduced or terminated by Waterstone if I do not adhere to the financial policy as stated above.

By signing below, I also agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

Printed Patient Name

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Patient Signature_____

Date_____