Lindner Center of HOPE
Professional Associates

4099 Old Western Row Road, Mason, Ohio 45040
513-536-HOPE (4673)

MEDICAID PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I (or the patient named below) am eligible to receive health care benefits through Medicaid.

I understand that the care, treatment and services I seek for myself (or the patient named below) from the Lindner Center of HOPE might be Medicaid "covered services". That means that benefits under the Medicaid program might be available to pay for some or all of the care, treatment and services sought.

I wish to assume financial responsibility for all charges associated with the care, treatment and services described below:

- ☐ Inpatient mental / behavioral health care and treatment
  - ☐ Facility and professional services
  - ☐ Professional Services
- ☐ Residential Treatment
- ☐ Outpatient mental / behavioral health care and treatment

Available information about diagnosis, nature of the proposed treatment plan, estimated duration of care and treatment, or estimated fees associated with treatment follows: _____

_____

_____

_____

I acknowledge that any diagnosis, fee estimate, or description of the treatment plan that is provided above is likely to be revised once care and treatment is initiated. Unless a decision is made that the level of care checked above is not appropriate for me (or the patient named below), or the duration of care and treatment is substantially exceeded, the Center will not be required to provide an update to any disclosure made above about the nature of the treatment plan, estimated duration of care and treatment, or fee estimate.

As result of my decision to assume personal financial responsibility for care and treatment to be provided to me (or the patient named below), I acknowledge that the Center will not be able to bill the Medicaid program, and Center agrees not to bill any third-party, including the Ohio Department of Job and Family Services, or any other Federal or State agency involved in the administration of the Medicaid program within the State of Ohio.

Payment Responsibility: As result of my voluntary decision to waive any benefits or reimbursement that would otherwise be available through the Medicaid program for this care and treatment, I acknowledge that I am financially responsible for all charges associated with health care services provided by the Center to me (or the patient named below). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

Late Cancellations or Missed Appointments: I understand that I am required to provide at least 24 hours advance notice if I (or the patient named below) am unable to keep a scheduled appointment. In the event that I do not provide 24 hours advance notice, I acknowledge that the Center has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come to the Center at my (or the patient's) scheduled appointment time, I understand that the Center will charge me for the scheduled appointment. I agree to pay the Center any late cancellation or missed appointment charges.

I fully understand and agree to the Center's policies and conditions described in this agreement. A copy of this agreement will be made available upon request.

Patient Name: _____
Last First Middle

Patient/Parent/Guardian Signature: _____

Printed Name: _____ Date: _____