LAKE COUNTRY ASSOCIATES, INC.
515 Bridge Street East, Park Rapids, MN 56470 ph: 218-366-9229
1426 Bemidji Ave NW, Ste 1 Bemidji, MN 56601 ph: 218-444-2233
11 Main Street East Menahga, MN 56164 ph: 218-564-9229
Fax: 218-237-2520

Client Name:_____ DOB:_____

By signing below as a client of Lake Country Associates, I agree to the following statements with regard to payment for services:

1. Clients are required to pay for services received. A client may choose to bill a third party insurance including Medical Assistance and Medicare. In the event that the third party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to Lake Country Associates and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at the time they are received. A 10% discount is offered for full cash payment at the time of service. Billing arrangements accepted by LCA other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
4. If a billing arrangement is made, a minimum payment of $75 per month or 10% of the total bill, whichever is higher, will be expected.
5. Any services provided by LCA not covered by client's insurance which are 60 days in arrears will be charged monthly interest at a rate of 1.5% of the balance.
6. In the event of non-payment, the bill will be sent to collections.
7. LCA reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.
8. The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify LCA.

SPECIAL CONDITIONS:_____

Charges for services are to be billed to the following sources:

☐ Insurance (primary)
Company_____ Subscriber Name_____
Group #_____ Subscriber _____
Policy #_____ Subscriber Relationship_____
Co-Pay Amount _____ Subscriber Address _____

☐ Insurance (secondary)
Company_____ Subscriber Name_____
Group #_____ Subscriber dob _____
Policy # _____ Subscriber Relationship_____
Co-Pay Amount _____ Subscriber Address _____

☐ Medical Assistance Carrier_____ MA#_____

☐ EAP Provider Name_____ Number of sessions_____

By signing below I understand if coverage has lapsed, if services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize LCA to furnish information to the payment sources concerning my illness and treatments and hereby assign to Lake Country Associates all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. I understand my insurance carrier or other third party payer may inform the "subscriber" of any services billed to the payer.

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☐ **Private Pay Clients:**

Name_____ Relationship_____

Address _____ Phone # _____

By signing below I agree that payment for services requested is the responsibility of the patient or guardian. I agree to accept the terms and conditions as indicated on the FEE SCHEDULE and PAYMENT CONTRACT. Any financial assistance that applies to these services is listed in the payment contract.

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_____ _____ _____

Client or Guardian Signature **Date** **LCA representative**