1005 S. U.S. 27, Suite 100, St Johns, MI 48879
Phone: 989-224-3000 Fax: 989-668-0423

Suboxone Financial Agreement

Your signature below forms a binding agreement between Clinton County Medical Center (CCMC – the provider of medical services) and the patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. While our staff will try to aid you in working with your insurance company, ultimately it is your responsibility to check with your insurance.

The person signing on behalf of the client as the Responsible Party must:

- Inform CCMC of the current address and phone number for the patient and the responsible party.
- Picture identification is required at each visit.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Deductibles and co-pay's are required to be paid at the time of service or you may be asked to reschedule your appointment.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that CCMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% ARP, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Cancelation – No Show Policy

Please note the providers at CCMC are in direct contact with the counselors at CCMC Psychological Services to make sure we give you the best care.

- If you have not had a counseling appointment, you will not receive your prescription and will still be responsible for the office visit charge.
- If you no show an appointment, you will be charged for the entire office visit. (Office visit fees start at $50 and are subject to change without notice.)

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Patient Name (Please Print)

____ ____________________
Patient Signature Date

____
Responsible Party Name (Please Print)

____ ____________________
Responsible Party Signature Date