FINANCIAL CONTRACT

CASE#: _____ DATE: _____ ORIGINAL: _____ REVISED:_____

Client Name:		**Social Security Number:**		
Head of Household:		**Social Security Number:**		
Person Responsible for Bill:		**Place of Employment:**		
Street:	**City**	**State:**	**Zip:**	**Phone:**
Medicaid Number:		**Medicare Number:**		
Primary Insurance Co.:		**Policy Number:**		**Group No.:**
Secondary Insurance Co.:		**Policy Number:**		**Group No.:**

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

1. I understand that the New Dimension Group has established a fee for each service provided.
2. I hereby agree, whether I am signing this document as a client of New Dimension Group or as an agent for a client, in consideration for the services and treatment received, to be personally responsible for the full amount due for such services and agree to make payment upon demand.

ASSIGNMENT OF INSURANCE BENEFITS

1. For services rendered by New Dimension Group to the client named herein, I hereby assign and transfer to New Dimension Group all of my rights to any medical benefits payable to me or to a beneficiary under the above listed insurance policies and any other policies not referenced above which may be determined to cover such services. Payments from insurance benefits will not exceed the New Dimension Group regular charges for the services rendered. By this statement I authorize payment directly to New Dimension Group of all benefits payable under the aforesaid policies.

2. I understand I am financially responsible and agree to pay upon demand for any and all charges not covered as a result of this assignment. This includes the difference between charges for certain services and reimbursement received from third party payers. If such indebtedness is placed in the hands of a collector or an attorney for collection, I agree to pay reasonable collection fees and interest, attorney's fees, and other reasonable expenses.

3. I certify that all information given by me in applying for payment under Titles XVII and XIX of the Social Security Act or under any hospital benefit policy, medical insurance policy, injury benefit policy, or any other comparable arrangement for third party reimbursement by any other name or designation is correct. I understand that New Dimension Group will demand full payment of all obligations in the event the information is found not to be correct.

RELEASE OF INFORMATION

I hereby authorize the release of information to insurance companies, Medicaid, Medicare, and other parties responsible for payment; such information will include date and nature of service (including treatment for alcohol and drug abuse) charge for services delivered, diagnosis, clinician, and anticipated length of treatment. This information will be released for the purpose of filing for insurance benefits and other financial coverage.

Client Signature: _____