SILVER HILL THERAPEUTIC SERVICES, LLC **208 Valley Road** **New Canaan CT 06840**	**Agreement to Pay for Non-Covered Services**	**Patient Name:** _____

I, _____, understand that the residential treatment offered by Silver Hill Therapeutic Services, LLC, is out-of-network with my insurance plan. Therefore, all services I receive from Silver Hill Therapeutic Services are entirely on a self-pay basis. I also understand that if my insurance plan offers out-of-network residential benefits, Silver Hill Therapeutic Services, LLC, will attempt to obtain authorization on my behalf. I further understand that authorization and OON reimbursement is not guaranteed.

I acknowledge that I have been advised that I will be responsible for the payment of any non-covered services and any outstanding balance.

_____	_____	_____	_____
Signature of Patient or Guarantor	Print Name	Date	Relationship to Patient

_____	_____	_____
Witness	Print Name	Date