CONTRACT FOR SERVICES

Client Name: _____ Date: _____

FEE DETERMINATION FOR CLIENTS <u>WITH</u> INSURANCE BENEFITS: Most insurance policies cover some portion of our professional fees. We do accept insurance assignments including Medicaid and Medicare and will be glad to file claims for services directly to the insurance company. However, it is the client's responsibility to provide ELC with **<u>all</u>** the information necessary to submit claims, including a copy of the insurance card, the member identification number, the birth date and social security number of the policy holder, etc. It is also the responsibility of the client to provide ELC with updated information if the client's situation changes. In addition, it is the responsibility of the client to contact his/her primary care physician for a referral and/or to pre-certify treatment if required by the insurance company. Failure to do so can result in the claim being denied and the client being responsible for the full fee.

ELC will contact the client's insurance company and verify benefits prior to providing services whenever possible. However, benefit information provided by the insurance company to ELC is not a guarantee of payment. The client's insurance policy is a contract between the client and the insurance company, and the client is also expected to contact his/her insurance company to obtain a thorough understanding of his/her benefits. It is the responsibility of the client to provide his/her insurance company with all the information required to process claims for the client. ELC is not a party to that contract. Insurance claims are filed at our customary Center charge. **If the client's insurance company does not reimburse ELC in the amount of our customary Center charge, the client is only responsible for the co-pay or co-insurance. If the client has a deductible to meet, the insurance company will notify ELC and will bill the financially responsible party accordingly.** If ELC receives payment from the client and the client's insurance reimbursement totals more than ELC's customary charge, the client will be credited.

Insurance companies including Medicaid and Medicare have differing licensing requirements regarding which therapists, which therapy procedures and which diagnoses for which coverage applies. ELC will attempt to assign the client to a therapist for whom the insurance company will pay and will advise the client as soon as possible if his/her insurance denies payment for services. If a therapist covered under the client's plan is not available, the client will be assigned to a non-credentialed therapist and the client will be advised that he/she will be responsible for full fee for services.

As of the date shown below, the client's insurance company, _____, has quoted the following benefits:

_____

_____

_____

Please note that the benefits quoted by the insurance company are not a guarantee of payment and the client is responsible for payment of all services not covered by the insurance company. This information is based on medical necessity at the time services are rendered and payment of fees received. It is possible that the insurer may not cover some service providers and services of ELC including specialized testing or assessments. ELC does not take responsibility if the insurance company refuses to pay for services received at our Center.

FEE DETERMINATION FOR CLIENTS <u>WITHOUT</u> INSURANCE BENEFITS: The fee for clients who reside in Franklin or Miami County who are without mental health insurance benefits will be based on their ability to pay for services. In order to determine "ability to pay", the Elizabeth Layton Center (ELC) has adopted a sliding fee scale which takes into consideration the resources of the family and the number of family members dependent on those resources. Our cost to provide mental health services varies by the service. **Clients are required to supply proof of their gross household income prior to or at the time of the intake.** Without income verification, the sliding scale fee cannot be assessed and the client will be responsible for the full fee. In addition, clients are required to provide updated proof of household income either on an annual basis or immediately upon a change in their situation. As of the date shown above, the above client (or responsible party) verifies that his/her gross annual household income is $_____ and that the number of household members is _____. Based upon this information, the above client's fee for an intake is $_____ and the fee for 45-50 minutes of individual therapy is $_____. Fees for other services will vary. A rate quote can be obtained from the Intake Coordinator or Billing Department upon request. _____

Clients must pre-pay for all court-ordered psychological testing, parenting assessments, and evaluations. Fees are based on time spent with the client plus time required for scoring and interpreting test results. ELC does not submit claims to insurance companies for court-ordered services unless medical necessity can be established. **Substance abuse treatment is not available at the sliding scale rate.**

FEE DETERMINATION FOR CLIENTS RESIDING OUT OF COUNTIES: Clients residing outside of the counties of Franklin and Miami may be served, if time is available. Client will be charged full fee unless the client has health insurance.

FULL FEES: Intake Assessment $200; Individual Therapy $135; and Group Therapy $55
Medication Services: Medication Evaluation $200 and 15-minute Medication Check $100
SA Intake $120; SA Individual Therapy $135, and SA Group $30/$55 depends on income verification.

PAYMENT METHOD: Payment is required at the time services are rendered. Payment may be made by cash, check, credit or debit card. If, after submitting claims to the insurance company, the client is responsible for more than the anticipated portion of fees, a monthly statement will be sent to the client and the client is expected to make payment in full within 30 days. Failure to pay may result in a delay of services and unpaid balances may be sent to the Kansas Setoff Program.

FEE REDUCTIONS: Clients who are undergoing unusual circumstances which affect their ability to pay may request a temporary fee reduction. The fee reduction request form is available upon request and will be reviewed and approved/ rejected by the Executive Director. Clients will be notified verbally and in writing of the decision.

MISSED APPOINTMENTS: In the event a client no shows for two scheduled appointments, ELC will follow the missed appointment policy.

CANCELLATIONS: Cancellations should be made within a minimum of 24 hours in advance of the scheduled appointment.

RESPONSIBILITY: The client (or the parent/guardian that brings the client in for services) is considered responsible for payment at the time services are rendered. ELC requires date of birth and the social security number of the responsible party.

I agree to pay the established fee. I understand that the fee is due at the time that services are rendered. I also understand my obligation to provide necessary insurance information or proof of household income in a timely manner if the client's situation changes.

_____ _____

Client's or Responsible Party's Signature Date

Elizabeth Layton Center, Inc.
Consent for Assessment & Treatment

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in a mental health assessment at the Elizabeth Layton Center. The purpose of the assessment is to determine my current mental health needs and to develop treatment recommendations.

Understanding Your Treatment. Treatment services are designed to help you, your child, or your family with your concerns. Benefits from treatment may include: improvement in daily functioning, improved relationships with others, improved behavior, and/or improved mood. At times treatment may be difficult; however, we will help guide you through this process. Elizabeth Layton Center does not guarantee the success of any treatment.

The assessment will consist of interviews, but I may also be asked to participate in psychological testing to more thoroughly evaluate my needs. I may also be asked to see additional professional staff who may participate in my evaluation and treatment.

I understand that my service provider may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing quality services to me. I understand that these discussions will be kept confidential unless I authorize that the information be released or unless allowed or required by law (e.g. in case of an emergency, necessary information may be shared with those providing emergency treatment and/or the individual(s) identified as my emergency contact(s)).

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the assessment is complete and a treatment plan has been formulated, I will be given the opportunity to review and discuss with my service provider the results of the evaluation, the nature of my condition, and any treatment, including alternatives to these recommendations.

I understand that this consent is **voluntary** and that I may withdraw my consent to treatment at any time.

Permission is hereby given to the Elizabeth Layton Center, Inc., to provide assessment and treatment to:
(Check One) ☐ self ☐ child ☐ other (specify) _____

Parents and Families. Therapy and psychiatric services are the most successful when both parents are involved in treatment of a child. For divorced or separated families, I understand as the parent consenting for the treatment of my child that I am responsible for notifying my child's other parent. Both parents may have access to the child's record, except in rare circumstances. If you have questions about this process, please ask your service provider.

I acknowledge having received a copy of the **Clients Rights and Responsibilities**, a copy of the Elizabeth Layton Center's **agency brochure** that outlines available services, and a copy of the Elizabeth Layton Center's **Notice of Privacy Practices** (as mandated by HIPAA regulations).

If medications should be prescribed or medical laboratory tests are required as a part of my treatment, I hereby give my consent to release my name to the pharmacy (or indigent program) that I obtain medications from to assist in filling and managing prescriptions for me. I also give my consent to release my name and my diagnosis (if necessary) for the purpose of requesting laboratory tests and obtaining results that may be needed as a part of my treatment. This consent for release of information will automatically expire upon close of my case at the Elizabeth Layton Center. I understand that I can cancel this release at any time by giving written notification.

_____ _____
Signature of Client or Responsible Party Relationship to Client

_____
Adolescent Child's Signature (14 – 18 years of age)

_____ _____
Witness Date