

CONTRACT FOR SERVICES

Client Name: _____

Date: _____

FEE DETERMINATION FOR CLIENTS WITHOUT INSURANCE BENEFITS: The fee for all clients without 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 scale fee 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. Without income verification, the sliding scale fee cannot be assessed and the client will be responsible for the entire customary Center charge. Clients residing outside of the county may be served, if time is available, but will be charged at a fee equal to the full cost of the Center's customary charge. Based upon the monthly income of your household and number of dependents, your sliding scale fee for outpatient services is \$_____ for an Intake or 45-50 minutes of Individual Therapy. Fees for other services may vary. A rate quote can be obtained from the Intake Coordinator upon request.

Fees for psychological testing, parenting assessments and other court ordered evaluations must be paid in cash before the appointment is scheduled. Fees are based on time spent with the client plus time required for scoring and interpreting test data. We do not bill court-ordered services to insurance companies, Medicaid or Medicare unless medical necessity can be established; therefore, the client is responsible for paying all fees relating to these services.

FEE DETERMINATION FOR CLIENTS WITH INSURANCE BENEFITS: Most medical insurance policies cover some portion of our professional fees. We do accept insurance assignments and will be glad to file the insurance claim for the client. It is the client's responsibility to provide ELC with all the information necessary to submit a claim to the client's insurance company (the insurance company name, phone number to call for benefits, policy or ID number and group number, and birth date of the policy holder). It is also the responsibility of the client to contact the primary care physician for a referral and/or to pre-certify treatment if required by the insurance plan. Failure to do so can result in the claim being denied and the client would be responsible for the entire customary Center charge. The client's insurance policy is a contract between the client and the insurance company. 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 ELC receives payment from the client and the client's insurance reimbursement totals more than ELC's customary Center charge, the client will be refunded.

Insurance companies including Medicaid and Medicare have differing licensing requirements regarding which therapists and therapy procedures for which coverage applies. We 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. After a disclaimer was explained, your health insurance company quoted your mental health benefits as _____

Please remember this information is merely a reflection of your mental health benefits currently on file with your insurance provider and in no way guarantees that payment will be made. This information is based on medical necessity at the time services are rendered and payment of fees have been 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.

PAYMENT METHOD: Payment is required at the time services are rendered. Payment may be made by cash, check or credit card.

FEE ADJUSTMENTS: Clients, who have unusual circumstances affecting their ability to pay, may request a fee adjustment. This form is available upon request and will be reviewed by the Utilization Review Committee and/or designee upon completion. Clients will be notified in writing of the decision.

MISSED APPOINTMENTS: In the event a client no shows for two scheduled appointments, payment will be required before rescheduling.

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

RESPONSIBILITY: The client (or the parent that brings the child in for services, in the case of minors) is considered responsible for payment of our professional fees at the time services are rendered. I agree to pay the above established fee. I understand the fee is due at the time services are rendered. I also understand my obligation to provide necessary insurance documentation as well as any change in my income or insurance coverage in a timely manner to the Center.

Client's or Responsible Party's Signature

Date