CLIENT PAYMENT AGREEMENT

CLIENT NAME: _____ CASE #: _____

Responsible Party Name: _____

Mailing Address: _____

Members of the Household:

Name:	Age:	Date of Birth:
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Total Household Monthly Gross Income: _____

Total Number of Dependents: _____

CLIENT FEE

I understand that I will be charged a fee for services received in accordance with the policies of WESTWOOD BEHAVIORAL HEALTH CENTER, INC. (WBHC) and the schedule below. Fees are based upon income verification and ability to pay. **I also understand that fees for all services are due at the time of service.**

$175.00	per hour for Intake/Diagnostic Assessment/AoD Assessment (1st visit)
$ 140.00	per hour for Individual/Couples/Family Counseling
$ 58.00	per Group Counseling Session
$258.00	per hour for Psychiatrist – Medication/Somatic Service (20 min. is normal visit)
$ 70.00	per Urine Drug Screen
$144.00	per day for group sessions in Intensive Outpatient Program (IOP), individuals sessions and EBAT and/or UDS are additional charges.
$200.00	per Domestic Violence Intake

I also understand that I may qualify for a discounted fee based upon family size and gross household income level. My fee share or co-pay per visit is:

$ ____.__ Intake/Diag. Assess.	$____.__ Med/Som
$ ____.__ Group	$____.__ Urine Drug Screen
$ ____.__ Individual	$____.__ _____

$ 15.00 Fee for missed appointments without 24-hour advanced notice.

These fees are to be paid at the time service is received regardless of other payer sources.

FAILURE TO NOTIFY THE CENTER OF A CANCELLATION OR NEED TO RESCHEDULE AN APPOINTMENT WITHIN 24 HOURS OF SCHEDULED APPOINTMENT TIME WILL RESULT IN A NO SHOW FEE OF $15.00, (MEDICAID, MEDICARE & ENTITLEMENT PROGRAM CLIENTS EXCLUDED) WHICH WILL BE YOUR RESPONSIBILITY TO PAY PRIOR TO NEXT SCHEDULED APPOINTMENT.

INSURANCE

I understand that certain insurance policies may pay a portion of the fees assessed for services received. My insurance company is _____. I agree to provide copies of membership card(s) and claim forms when required. I understand that I am responsible for the amount not covered by my insurance up to the full fee for service. I also understand that I am still responsible for my Co-Pay amount to be paid at the time services are received.

If the sum received through insurance and client fee payments exceeds the fee for service, the excess paid will be reimbursed to the Client after all services, and claims for services, are processed.

(Continued on Reverse Side)

THIRD PARTY PAYERS OTHER THAN INSURANCE

I certify that I am eligible for payment through the following resources. Identification cards, etc. are to be provided upon request.

☐ MEDICARE* Medicare Claim #: _____

The signature below authorizes payment of MEDICARE benefits be made to Westwood Behavioral Health Center, Inc. for any services furnished by that physician or organization. I authorize the Health Care Financing Administration to release any medical information necessary to determine benefits payable for related services.

☐ MEDICAID* Medicaid #: _____

Income Source and Amount

_____ ADC

_____ SSI

_____ SSDI

☐ TITLE XX* Date Title XX Application Completed: ____/____/____

Number of Dependents: _____

Eligibility Status (Check correct response) ☐ I.E. (Income Eligibility) ☐ W.R.I. (Without Regard to Income)

***Loss of Medicare, Medicaid or Title XX status, will result in my being subject to the sliding fee payment schedule. Currently, the minimum sliding fee is $20.00 per visit/hour of service payable at the time of service**.

☐ If I am no longer covered by one of the programs above, my sliding fee payment will be:
Approved Rate: $ _____ per hour/visit (CSP/CM services excluded)

EAP/MANAGED CARE PAYERS

I certify that I am an employee of _____ and that eligible services will be paid through my company's EAP contract with _____.

Approved Visits: ____ Diag./Intake ____ Ind. Couns. ____ Med/Som. _____ UDS

Approved Rates: $ _____ $ _____ $ _____ $ _____

Client Identification Number: _____

Is there a Client co-pay? ☐ YES ☐ NO (Check One)

If YES, describe: _____

RELEASE OF INFORMATION/ASSIGNMENT FOR INSURANCE PAYMENTS

I authorize payment of benefits directly to WESTWOOD BEHAVIORAL HEALTH CENTER, INC. for services rendered. I also authorize release of information (for insurance payment purposes only) that is protected by Federal Confidentiality rules (42 CFR, Part 2, Section 2.31 of PL-03-282). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. This information is also protected by HB 244 of the Ohio Revised Code (5122.3).

I also certify that I have read (or had read to me), understand, and have received a copy of Westwood Behavioral Health Center, Inc. fee policy, payment agreement, consent to treatment and confidentiality statement, Notice of Enrollment Disclosure, Notice of Privacy Practices and a copy of the Client Rights and Grievance Procedures. I understand that the Center does not discriminate against any individual based upon race, color, creed, sex, sexual orientation, national origin, religion, disability or economic situation including the ability to pay for services. The Center does not tolerate any form of harassment of clients or staff by any individual at any time. The Center is an equal opportunity employer and equal provider of services.

_____ _____

Client Signature **Date**

_____ _____

Responsible Party Signature **Date**

_____ _____

Interviewer/Intake Signature **Date**