Financial Responsibility for Payment of Services

Client's Name _____

Please read each section of this page carefully and initial at the end of each section to acknowledge you have read and understand the financial guidelines and responsibility outlined.

Fees are due at the time of service delivery. Cash, check, or credit cards are accepted forms of payment. Clients are responsible for payment of delivered services. We will attempt to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility including, but not limited to: deductibles, co pays, and any fee not covered by your insurance provider. X _____ (initial here)

We take payments and schedule for the next week at the beginning of each session. If you do not have your payment at the beginning of the session, we will have to reschedule to another time when you can make the payment. If your balance exceeds $100.00 you must sign a payment arrangement form, which will be given to you by the account's specialist. By signing this form, I agree to the financial responsibility of payment for the therapeutic services and any fees outlined in the fee schedule below. X _____ (initial here)

In the event your account is not paid within 90 days or your balance exceeds $500, collection proceedings may be instituted. If we must refer your account to collections, you will be responsible for all costs of collections including reasonable collection agency fees, attorney fees, and court costs.
X _____ (initial here)

Fees Associated With Services Not Paid by Insurance			Initials
"No Show" Fee		$50.00	x
"Late/Cancel" Fee (24 hours or less)		$40.00	x
"Return Check" Fee		$5.00 (or the amount charged to us)	x
Court Preparation and Court Reports		$75.00 per hour	x
Court Appearance per Counselor present	120 minutes minimum	$300.00	x
Letter request		$25.00 per letter request	x
Out of Session Contact		Starting at $20.00 (based on length of call)	x

As a courtesy to you, our billing department will assist you in submitting your insurance forms. **If, however, your insurance company does not pay the anticipated amount, you are still responsible for the total amount of the bill.** Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment. Ultimately, it is your responsibility to know the benefits of your policy and any changes that may arise. X _____ (initial here)

If you have insurance, please understand that it is an agreement between you and your insurance company. ***If your insurance company denies your visits for any reason, you will be responsible for the payment of the session on a "sliding fee scale" based on household income.*** X_____ (initial here)_____

I consent to release any personal or clinical information required to process my claim to my insurance provider listed on the back of this form. I also authorize any payments made by my insurance company to be paid directly to, NewSong Counseling Center, Inc. This form will be considered a signature on file for all future insurance claims. This release will expire 2 years from the date of your last appointment.
X _____ (initial here)

If there *any concerns with the NewSong Counseling Center, Inc., that you cannot discuss with your counselor, please contact the Executive Director, Cathy Turner @ (859) 497-0594.*

I certify that I have read and understand the *"No Surprise Billing Act"* and was offered a hard copy of information regarding the *No Surprise Billing Act* from NewSong Counseling Center, Inc. X_____ (initial here)

Insurance Information

Primary Insurance: _____	**Secondary Insurance:** _____
Name of policy holder: _____	Name of policy holder: _____
Relationship to client: _____	Relationship to client: _____
Member ID number: _____	Member ID number: _____
Group number: _____	Group number: _____

Please present your current insurance card before your session or provide a copy of the front and back of your insurance card to nscc.staff@newsongcounseling.org or text a picture to 859-497-0594.
If your insurance should change, please notify our billing office as soon as possible with the updated card information.

If you do NOT have insurance or DO NOT wish to bill insurance, we have a sliding scale fee you may apply for. Our sliding scale fee is based on gross annual household income. Our fee scale ranges from $25-$100 per session. In order to apply, we will need income verification (copy of tax return, pay stubs, etc.) at the first appointment. We will then work on financial agreement as part of the intake process and determine your sliding scale fee. With this system, no one is excluded based on income. Quality counseling services can be afforded by all.

Your Gross Annual Income:	$
If applicable, Spouse's Gross Annual Income:	$
Child Support/Alimony:	$
SSI:	$
Income from Rental Properties:	$
Pension/Retirement:	$
Other:	$
Total:	$

For Admin Staff Only:

Admin Initials_____

Date _____

_____

Reference the ***Sliding Scale Fee Structure Chart*** to determine session fee.

Client agreed upon fee per 45-60-minute session:

I certify that I have read, understand, and agree to abide by the information outlined above concerning mental health services and the financial agreement. I hereby give my consent to authorize NewSong Counseling Center, Inc. to evaluate, treat, and/or refer me or my child to others as needed. I had the opportunity to discuss any questions regarding the above information.

_____

Client Signature Date Client (printed name)

_____

Parent Signature Date