CHiLD and FAMiLY
BEHAVIORAL HEALTH

Payment Agreement

Session Date/Time: Click or tap to enter a date.
Therapist: Choose an item.
Type of Service: ☐ MH ☐ SA
REMI Entry: ☐ Yes ☐ No

eThomas#:

CLIENT INFORMATION			
Client Name:		**Responsible Party:**	
Client DOB:		**Relationship to client:**	
Address:		**Address (if different):**	
City:		**City:**	**Zip:**
Phone:		**Annual Household Income:**	
		Number in Household:	
Primary Insurance:		Policyholder's Name:	☐ Client is Policyholder
Contract #:		Policyholder's DOB:	
Group#:		Relationship to Client:	
Secondary Insurance:		Policyholder's Name:	☐ Client is Policyholder
Contract #:		Policyholder's DOB:	
Group#:		Relationship to Client:	

COST OF SERVICES	
Today's Assessment:	**$**
Ongoing Individual and Family Sessions:	**$**

PLEASE NOTE: If Medicaid becomes inactive the Responsible Party listed will be charged based on our sliding scale once income verification has been received. For statistical and grant funding purposes, please provide Household Income and Number in Household above.

PAYMENT AT TIME OF SERVICE: Based on the information provided initially, I understand Child and Family Charities has verified and will invoice my insurance plan but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I agree to payment of the fee(s) indicated above to Child and Family Charities for services rendered. I agree to assign insurance benefits for covered services to Child and Family Charities so that my insurance company will reimburse the Agency directly. If insurance payment for services is made directly to me, I will submit all such payments to Child and Family Charities up to the full cost of services as indicated above. In addition, I understand the fees quoted on this agreement are estimates and will be subject to change once actual benefit payment or non-payment has been received. I understand the estimated co-pay as well as any portion of the charges not paid by the insurance will be due at the time of service. Further, I understand that if my account becomes delinquent, services may be suspended and a collection process will be pursued.

CHANGES IN INCOME OR INSURANCE: I will promptly notify Child and Family Charities if my income, number of dependents, insurance coverage or any other condition which affects my ability to pay should change. If services should continue beyond six months, a review of my fee will be made. *The information provided by me on this agreement is correct to the best of my knowledge.*

Client Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date:** _____
Witness Signature: _____ **Date:** _____

Updated: 02/05/20