360 Focus Mental Health Payment Agreement

Client Name		Date of Brith:	SS#
Responsible Party		Date of Brith	SS#
Mailing Address			

Client Fee

I understand that I will be charged a fee for services received in accordance with the policies of 360 Focus Mental Health and the schedule below. I also understand that fees for all services are due at the time of service.

$175.00	Per hour for Intake/Diagnostic Assessment (1st Visit)
$150.00	Per hour for Individual/Couples/Family Counseling
$58.00	Per hour for Group Session
$200.00	Per hour for Psychiatrist - Medication/Somatic Service (20 min is normal per visit)
	These fees are to be paid at the time service is received regardless of other payer sources.
$50.00	I also understand that there is a $50.00 charge for missed appointments - or for appointments that are not canceled 48 hours in advance.
$50.00	Note at the time an appointment is scheduled credit card information is required for the purpose of charging co-pays, no shows, for appoints that are not cancelled 48 hours in advance, and to cover any balances not cover if insurances are billed.

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 payments exceeds the fee for service, the excess paid will be reimbursed to the Client after all services, and claims for services, are processed.

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

Insurance Information	
Name of Insurance Holder	
Card Number	
Policy Number	
Contact Number for Insurance	
Contact Number for Policy Holder	

Release of Information/Assignment for Insurance Payments

I authorize payment of benefits directly to 360 Focus Mental Health, LLC. 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. I also certify that I have read (or had read to me), understand, and have received a copy of 360 Focus Mental Health Services. 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.

Credit Card Information Kept on file to bill for no-shows, co-pays, and services not covered by insurance and for self pay clients

Credit Card Information	
Name On Card	
Card Number	
Expiration Date	
CV Code	
Address for Card	

Client Signature		Date:
Responsible Party Signature		Date:
Interview/Intake Signture		Date: