Financial Agreement between Columbia County Department of Human Services/Mental Health Center and

Client's Name Date of Birth

The staff at Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC) respects and assures your rights to privacy, confidentiality and dignity of treatment at all times.

The mission of CCDHS/MHC is to foster the health and welfare of residents of Columbia County by providing mental health services to adults, children and families especially to those who have no other provider options.

The staff at CCDHS/MHC will keep scheduled appointments, except in the case of an emergency or illness. If cancellation is necessary, CCDHS/MHC will attempt to do so 24 hours in advance of the scheduled appointment.

The staff at CCDHS/MHC works as a multi-disciplinary team and may consult amongst one another to develop an appropriate course of treatment for each client.

Clients may be asked to sign "Authorization to Use or Disclose Protected Health Information" consents so that CCDHS/MHC can obtain information from other sources and/or providers. However, in the event of an emergency, information may be provided to the emergency contacted listed in this Agreement, without the client's consent and/or to other appropriate providers/agencies deemed necessary concerning such emergency.

CCDHS/MHC will attempt to ensure client's appointments begin promptly.

The work of CCDHS/MHC is funded through insurance reimbursements and client fees which are a critical source of income supporting the continuation of our purpose.

Client's failure to uphold financial responsibility impacts CCDHS/MHC's ability to provide services to others.

Payment for service is due at the time of service. Co-pays are due for *each* service on a given day. Cash, check, MasterCard/Visa and Discover are acceptable forms of payment. If paying by credit card, there is a fee of 2.35% plus $1.00 automatically added to the amount being charged. This fee is imposed by the banking/credit card industry and is not kept by CCDHS/MHC. This fee is subject to change.

It is the client's responsibility to know the level of coverage for services any payment by their insurance company. The client is responsible for any amounts not covered by their plan.

If the insurance plan requires a referral, the client is responsible for working with the insurance company and with CCDHS/MHC to ensure that this is in place. If CCDHS/MHC is an **in-network provider** with the insurance plan, co-pay is expected at time of service.

As an **in-network provider,** CCDHS/MHC will bill the insurance company for reimbursement. If CCDHS/MHC's charges apply to the client's deductible, or are not covered by the insurance plan, the client is responsible for any unpaid amounts.

It is the client's responsibility to notify CCDHS/MHC of any changes in insurance. Failure to notify CCDHS/MHC of changes in insurance *does not* alleviate the client's responsibility for full payment of services rendered. CCDHS/MHC reserves the right to discontinue contracting with insurance providers with 30 days advanced notice.

There are some services that CCDHS/MHC may provide to you that may not be covered by your insurance plan or may incur co-pay such as drug/alcohol screenings, court testimony, reports, copies of medical records, etc. Should you require these services; fees will be discussed with you. Co-pays are determined by your insurance company. In order to release your medical records outside of this agency, you will be required to sign an approved release of information form.

For clients who are not eligible for insurance for which proof has been provided, CCDHS/MHC offers a sliding fee scale. You will be asked to complete a fee sheet and bring in specific documentation such as pay stubs or tax returns to verify your source(s) of income. CCDHS/MHC will apply that information to an approved fee chart and determine your financial responsibility. You will be notified by the CCDHS/MHC Billing Department once this fee is established. Please note that this fee applies to each and every session including individual, group, and family therapy sessions. This fee will also apply whenever you see one of CCDHS/MHC's prescribers**.** Eligibility for remaining on the sliding scale will be reviewed every 6 months and you will be asked to provide updated information. ***For Medicaid pending clients you must provide proof from the Department of Social Services of your pending status.***

It is understood that it is the policy of CCDHS/MHC that:

1) A $10.00 "no show fee" will be charged to clients for any missed appointment and any appointment NOT cancelled and/or rescheduled before 4 pm the day before the clients scheduled appointment. Insurance companies do not pay this fee. I understand that a pattern of missed or cancelled appointments will be interpreted as a lack of readiness to commit to therapy and further appointments may not be afforded to you.

2) Fees incurred for returned bank checks, for any reason, are the client's responsibility.

3) If services are rendered at a school satellite, any co-pays or other fees due will be billed to the responsible party listed in the chart.

4) If you have not been active in treatment for three (3) months or have failed to pay for services, your case may be closed. Your case may remain open if it is clinically indicated and is approved by your clinician's supervisor. If you wish to return after you have been discharged from treatment, you are welcome to call and request a new intake appointment. **Any money owed to the CCDHS/MHC must be paid in full, or a repayment plan must be established.**

5) **As previously noted all insurance co-pays, deductibles and sliding scale fees and any other fees that might be incurred by securing services at CCDHS/MHC are expected to be paid in full and always at the time of service.** If you incur a financial hardship and are having difficulty in meeting your financial obligation, please ask to speak to the engagement specialist. All reviews of financial hardship concerns will be conducted on a case by case basis, and any

payment plan will remain your responsibility until your financial obligation is met. **Non-compliance with your payment plan may affect the level of services you receive.**

Crisis services are available 24 hours a day to anyone in Columbia County regardless of participation in our services. If you feel you are at immediate risk of harm, ask to speak with a crisis screener. Crisis screeners are available in person or on the phone during clinic business hours; or if the clinic is closed, can be reached by calling the main clinic phone number, 518-828-9446.

Please Note: CCDHS/MHC utilizes the PMP (Prescription Monitoring Program) at admission as part of the assessment process to get a complete picture of the individual's medication profile. It may also be used periodically throughout the treatment process. The PMP is a registry of all controlled substances prescribed for individuals in New York. Use of the PMP is required prior to writing or filling any prescription for a controlled substance in the State of New York. Other states have similar databases, and those will be consulted if necessary. If you have any questions about this issue please contact our Medical Director, Carlos Valle, MD.

I understand that I am responsible for all charges and fees. I give CCDHS/MHC permission to release any information, including psychotherapy notes that is necessary to support any insurance claims on my account and secure timely payments due to the assignee or myself. If CCDHS/MHC is an in-network provider for my insurance plan, I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid directly to CCDHS/MHC. This assignment or a photocopy hereof is acceptable.

I have read and understand the above policies. To the best of my knowledge, I certify that all financial and insurance information that I have provided is accurate and complete and I will inform CCDHS/MHC of any change(s) in my circumstances.

Signature of Client *(or legal representative if client is a minor)* Date

Witness Date

Clinic Use Only:

Client/Legal Representative received copy of this Agreement:

☐Yes ☐No *(declined)*

Date_____ Staff Initials_____