CONSUMER NO: _____

RU: _____

FEE POLICY STATEMENT

SELF-PAY FEES

The Center's fee for outpatient services is $124.00 per hour. As a consumer of E.C.M.H., you are eligible for a discounted fee based on your annual income and family size. All persons regardless of insurance, Medicaid, Medicare or other third party payer are eligible for this discount and will receive a determination of the self-pay fee at the time of the initial visit.

In order for us to make this discount available to you, it is important that payment is made when the service is received. Failure to pay your discounted fee could result in losing your discounted fee status and services will be billed to you at the full $124.00 per hour rate.

NON-DISCRIMINATION POLICY

No Service will be denied based on race, religion, color, sex, national origin, disability, sexual orientation, or inability to pay.

INSURANCE

The Business Office will process all insurance, Medicaid, or Medicare claims. For individuals with insurance we encourage you to make payments based on your discounted fee at the time of the service to apply toward amounts not covered by your insurance.

After application of insurance and Medicaid benefits, you will be billed at the discounted rate for non-covered services or partially paid claims. Medicare recipients will be billed at the applicable rate. If you have any questions or problems concerning your statement, please use the account number on the monthly statement to request clarification of your statement.

RELEASE AUTHORIZATION

I, _____, hereby authorize East Central Mental Health to release to

Consumer

_____, information regarding services provided for billing purposes.

Agency *I* Individuals

This consent may be terminated at any time by the consumer, but terminating this consent will not cancel any action that has already been taken as allowed by this form. The release can be revoked in writing except to the extent that the covered entity has taken action in reliance on it. Unless the consumer wishes to cancel this consent at an earlier time it will automatically stop when all fees have been collected.

_____ _____ _____ _____

Consumer's or Authorized Person's Signature **Date** **Witness Signature** **Date**

AUTHORIZATION OF PAYMENT

I authorize the release of any medical or other personal health information necessary to process all claims. I also request payment of government benefits to East Central Mental Health, who accepts assignment.

_____ _____ _____ _____

Consumer's or Authorized Person's Signature **Date** **Witness Signature** **Date**

I authorize payment of any medical benefits to East Central Mental Health and clinician or physician of record for services rendered and described in claims for the duration of the services received at East Central Mental Health.

_____ _____ _____ _____

Consumer's or Authorized Person's Signature **Date** **Witness Signature** **Date**

This consent may be terminated at any time by the consumer, but terminating this consent will not cancel any action that has already been taken as allowed by this form. The release can be revoked in writing except to the extent that the covered entity has taken action in reliance on it. Unless the consumer wishes to cancel this consent at an earlier time it will automatically stop when all fees have been collected.