Client Name: ___________________________________ **Date of Birth:** _______________

FINANCIAL AUTHORIZATION

I AUTHORIZE payment directly to Foundations Behavioral Health Services, Inc. (Foundations) of the benefits herein specified and otherwise payable to me but not to exceed the regular changes. I understand that I am responsible for all charges until the bills are paid in full and for the balance of charges not covered by insurance.

If I should qualify for partial public funding, I understand I am responsible for the portion of the charge that the Tri-County Board does not cover.

MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize Foundations to release to the Social Security Administration and/or Medicare program any information needed for this or a related Medicare claim. If for any reason Medicare (or my insurance company) denies payment, I authorize Foundations to act on my behalf to appeal for payment. I understand that not all Medicare plans are accepted as payment in full for services. At this time, the Red/White/Blue Medicare cards are the only coverage accepted in full for payment.

I understand that I am responsible for my co-pay, deductible, co-insurance and/or charges my insurance does not cover and that payment is expected at the time of service. If my financial situation/family size should change or changes occur in my insurance, Medicaid or Medicare benefits, I agree to inform Foundations promptly. If I choose not to do so, Foundations reserves the right to bill me at the full, standard rate for each service (listed below.) I agree that Foundations or our contracted Collections Agency may contact me by mail or by phone at my residence or place of employment if I am more than 90 days delinquent on my account. I understand that I may not be seen for non-emergency behavioral health services if my account is past due and I have not entered into a payment agreement with Foundations OR if I have not provided necessary financial information in order for Foundations to complete the billing process.

Foundations accepts cash, checks, and credit/debit card payments. Payment with credit or debit card may also be made online at www.foundationsbhs.org. Returned checks are subject to a $40.00 fee.

Temporary financial problems may arise periodically and affect timely payment on your account. If I have any questions about Foundations' billing process and my payment obligations, I can discuss them with the Accounts Specialist.

Signature of client/patient or legal representative or agent ______________________________ Date ______________________

INSURANCE RESPONSIBILITIES

Your insurance coverage is a contract between you and your insurance company. Foundations is not a party to that contract, and not all services provided to you by Foundations may be considered covered by your insurance company. Medical benefits, including co-pays and/or co-insurance benefits are likely to be different than Behavioral Health benefits. At times, Behavioral Health benefits are covered through a different insurance company than the company that carries your Medical benefits. It is your responsibility to know what service is covered under your policy and to check with your insurance company to verify whether the service to be provided is covered. As a standard procedure, Foundations will bill your insurance company for services rendered. Please note that most insurance companies will not cover court-ordered services. If your insurance does not cover these services, you will be responsible for the full fees for services (listed below.)

Signature of client/patient or legal representative or agent ______________________________ Date ______________________

FEE SCHEDULE FOR SERVICES

Service	Fee
Psychiatric Assessment (1st Doctor Visit)	$325.00 per hour
Diagnostic Assessment	$134.00 per hour
Group Therapy	$34.00 per hour

Service	Fee
Psychiatrist Appointment	$285.00 per hour
Individual Counseling	$123.00 per hour
Rapid Drug Testing	$25.00 per test**
IOP	$180.00/session

*****No Discount on Drug Testing/Payment Due At Time Of Service on All Services*****

FOR OFFICE USE ONLY: Is client School-Based? YES / NO Client on an IEP? YES / NO Staff Initials: _________