

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

FOR PRIVATE PAY:

You are required to pay your sliding-scale fee prior to each visit.

FOR INSURANCE BERT NASH CONTRACTS WITH (Blue Cross, HMS, Medicare, New Directions, Tricare, and EAPs):

We require a copy of your insurance card. Otherwise your fee will be set at our **full-fee**.

You are required to pay your co-pay, if applicable, prior to each visit.


Anything not covered by your insurance will be your responsibility. (For example: phone contacts, case management, and phone medication renewals)

FOR MEDICAID:

We require a copy of your medical card each month. Otherwise your fee will set at our **full-fee**.

There is a \$3.00 co-pay after the first visit to be paid prior to each adult therapy appointment.

Anything not covered by Medicaid will be your responsibility. (For example: phone contacts and phone medication renewals)

OVER 

Reg. ID# _____ Client Name: _____

FOR ALL OTHER INSURANCE:

We will bill your insurance as a courtesy to you. We require a copy of your card otherwise your fee will be set at our **full-fee**.

You will be required to pay your sliding scale fee prior to each visit. If payment is received from insurance, your account will be credited.

Anything not covered by your insurance will be your responsibility. (For example: phone contacts, case management, and phone medication renewals)

Your sliding scale/co-pay based on an annual income of _____

_____ initial visit
_____ 1 hour of individual treatment-not including psychiatrist
_____ medication management with a psychiatrist-up to 30 minutes
_____ for one hour of service with a psychiatrist
_____ for each hour of group therapy
_____ phone prescription refills or phone consultation
_____ insurance co-pay
_____ Medicaid co-pay

I further understand and accept that services may be discontinued if I choose not to pay the sliding scale/co-pay fee at each visit.

By signing this form I acknowledge that this information has been explained to me and that I understand and accept financial responsibilities.

Client or Guardian Signature

Date

Witness Signature

Date

OVER 

Reg. ID# _____ Client Name: _____