# FAMILY GUIDANCE CENTER
# **Financial Obligation Policy/Agreement**
# **For all Insured and Uninsured Clients**

We at Family Guidance Center would like to welcome you to our family and thank you for choosing us for your mental health needs. We are committed to providing you with the highest quality of care.

Please read the following to acknowledge your understanding and agreement to abide by our Financial Obligation Policy:

I, as the client or guardian, will present any and ALL active insurance information to the staff at Family Guidance Center. This would be in the form of insurance cards or electronic cards on the insurance website.

I will be responsible for any insurance deductible, co-insurance and/or copay that my insurance designates as my responsibility. I will also be responsible for any services provided that are not covered by my insurance and understand that it is my choice to obtain the said non-covered services. Copays are required at the time of service, prior to these services being rendered. Payment will be accepted in the form of cash, check or major credit card.

I understand that there is sliding fee that I may qualify for, if I DON'T have active insurance and I meet the income requirements. I understand that it is my responsibility to provide the appropriate paperwork to prove income, in order to be considered for the sliding fee scale. I agree to pay the amount designated by Family Guidance Staff, for each service rendered.

I understand that it is my responsibility to be familiar with my specific insurance benefits prior to treatment beginning. It is my responsibility to contact the insurance or the employer with any questions that I may have, specific to my policy/plan.

I hereby authorize direct payment of behavioral health benefits to Family Guidance Center. If my insurance reimburses me directly for services provided at FGC, I am aware that I must turn this payment over to FGC immediately. I am also aware and in agreement for FGC to provide all necessary client health information, included HIPAA protected information to the insurance company for payment purposes. This authorization will remain in effect until I provide written request to terminate the assignment to FGC.

I understand that if I don't have behavioral health coverage through my insurer, or LOSE my coverage, that I MUST apply for Sliding Fee or I will be financially responsible for all services rendered at full rate, until coverage is re-instated.

**I acknowledge the above and agree to adhere to the Financial Obligation Policy/Agreement For all Insured and Uninsured Clients to the best of my ability by signing the Consent Agreement Form 111-MH.**