FAMILY COUNSELING & CHILDREN'S SERVICES
FINANCIAL POLICY

Case No.: _____

Insurance Coverage: There are thousands of insurance plans in Michigan. Therefore, it is impossible for our office to know the covered benefits of all insurance plans. We advise that you be familiar with your insurance policy and benefits including information regarding co-pays, physician referrals, and reauthorizations and credentials of therapist. When the receptionist calls your insurance carrier at the time of your visit, that conversation is not a confirmation or guarantee of payment or benefits. Your insurance company will determine what benefits are payable once a claim has been submitted. Any co-payment collected from you at the time of service is an estimate of your financial responsibility.

Medicaid Insurance Clients: We only accept Meridian Health Plan and United HealthCare Community Plan. If your benefits with either of these plans are terminated and you have received services your fee will automatically be adjusted to the minimum sliding scale rate of $35.00 per session starting on the date your insurance was terminated regardless if you are eligible for straight Medicaid. These charges will be your financial responsibility.

Regarding Non-Participating Insurance Companies: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company. You are ultimately responsible for the bill in its entirety. Your insurance is being billed by our office as a courtesy to you.

Regarding Participating Insurance Companies: There are certain insurance companies we participate with and accept their payment as payment-in-full, excluding any co-payments or deductibles indicated in your contract. You are still required to know the rules and regulations of your insurance carrier and obtain any required referrals or documentation in accordance with those rules. Major Medical Insurances often pay the policy holder. When this occurs you are responsible for making that payment to us as soon as that payment is made. Failure to do so will result in payment in full being requested at the time of service.

Regarding Clients Without Insurance: For clients not covered by insurance the fee is set on a sliding scale according to family size and income. The scale ranges from $35.00 up to current service cost. Your fee will be set at actual service cost until you bring proof of income (pay stub, W-2, etc.) to the office.

Adult Clients: Adult clients age eighteen or older are responsible for their own bill. Any agreements between parents, spouses, or other relations to take care of the bill are between the client and that person, not Family Counseling and Children's Services.

Minor Clients: The parents of the minor child are responsible for the bill. In the event the parents are divorced, the parent accompanying the minor is financially responsible, regardless of the divorce decree. Settlement must be resolved between the parents.

Missed Appointments: If you are unable to keep your appointment, please call at least 24 hours in advance to reschedule. After your first missed appointment with less than 24 hours' notice you will be billed $25.00 for missed appointments with the Therapist and $50.00 for the Doctor. No insurance pays for missed appointments and this charge will be your responsibility.

I have read and understand this financial policy.

Signature: _____ Date:_____ FCCS initials_____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

All Clients Fill Out: **Case No: _____**

Client Name: _____ Name of Responsible Party (for minor)_____

Client's S.S. #:_____ S.S.# (Responsible Party): _____

Date of Birth:_____ Marital Status: Single Married Divorced

Home Phone: _____ Work Phone: _____ Employer: _____

Address: _____ City: _____ Zip: _____

For Sliding Fee Scale Clients:
Gross Family Income: Weekly: _____ Yearly:_____ # in Family:_____

PLEASE INCLUDE PROOF OF INCOME**
I have read and understand the financial and payment policy and agree to these terms. My fee has been set at $ _____ per session. Payment is expected at the time of services.

_____
Signature of Sliding Fee Scale Client Date

For Insurance Covered Clients: Annual Household Income: $_____

Please remember to provide your card for us to copy

Primary Insurance Company #1: _____

Policy Holder: _____ Relationship to Client: ____ Self ____Spouse ____Parent

Policy Holders Date of Birth: _____ S.S. # _____

Secondary Insurance Company #2 _____

Policy Holder : _____Relationship to Client: _____ Self _____Spouse ____Parent

Policy Holders Date of Birth _____ S.S. # _____

I have read and understand the financial and payment policy and agree to these terms. I also agree to pay any deductibles, co-pays, or charges not covered by my insurance.

I hereby authorize Family Counseling & Children's Services of Lenawee County to release information acquired in the course of my examination or treatment which is required to obtain reimbursements for services and to obtain benefits for which I may be eligible.

_____
Signature of Insurance Covered Client Date
Form 12