FamilyMeans
Financial Contract Policy

Client Name: _____
Client Date of Birth: ____

As a service to our clients, FamilyMeans will submit your insurance claims. Please provide us with necessary information to submit claims in a timely manner. If you fail to provide active insurance information in a timely manner, you will be responsible for the full balance. **Co-Payments, deductibles and co-insurances are to be paid at the time of each service at check-in.**

Client Name:_____DOB:_____
Address:_____City:_____St:_____Zip:_____
Phone: _____Email:_____

Do you have Insurance: ☐ Yes (continue with form) ☐ No (skip to Client Responsibility Section)
Insurance Type: _____ Group#_____ID#_____
Who is insurance through (Full Name)_____DOB_____
2nd Insurance Type: _____ Group#_____ID#_____
Who is insurance through (Full Name)_____DOB_____

Client Responsibility (Please Initial & Check the Following):

_____Insurance Coverage
It is client's responsibility to know what is and is not covered under their insurance policy.
FamilyMeans can make no guarantee that your insurance company will provide payment for services rendered.
Clients are responsible for the full amount of the charge whether or not your insurance will cover any portion.
If your insurance company requires pre-authorization of services, you are responsible to inform us.
Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.
If your insurance has a high deductible, FamilyMeans requests payment of $75 at each session.
I will notify FamilyMeans if there is a change in my insurance, income, number of dependents, or if I obtain other applicable insurance coverage.
If there is an outstanding balance from previous services, FamilyMeans requests payment prior to initiating new services.

_____Cancellation Fee $75
FamilyMeans requires a 24 hour notice when cancelling an appointment. This will allow us to offer the time to others.
At the discretion of FamilyMeans, your services may be discontinued due to excessive failed appointments or late cancellations.

_____Divorce/Custodial Situations
The parent/guardian whose insurance will be filed must sign the financial contract and receive billing statements.
Either parent who is legally able, may sign all other documentation. Any court-ordered financial arrangements must be worked out between the parents.

_____Interns
I am aware that FamilyMeans provides internship opportunities to mental health trainees who may be present or conduct all or part of sessions as part of their education. All fees and billing do remain the same when interns are present.

Authorization to Release Information

I, _____(client/legal guardian if client is under 18), hereby authorize FamilyMeans to release all information necessary to secure payment for services rendered and to mail payment statements. I understand that my records are protected by the Data Privacy regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations, and that I may revoke the consent at any time. I understand that this consent will automatically expire without my express revocation upon receipt of all payments due. I have the right to receive a copy or review information to be disclosed if requested.

_____

Responsible Party Signature Date