Counseling Services

Financial Policy and Agreement

The Mental Health Association's Counseling Service program provides ongoing Therapy and Medication Management to clients as appropriate. The program bills these services to Medical Assistance, Medicare, and to the individual being served. All payments for services are expected to be paid at the time of service. Any portion of payment not covered by the client's insurance is sole responsibility of the client.

____Medical Assistance:
Medical Assistance (MA or State Insurance) typically pays 100% of fee for service. Any deductible or copay will be assessed and billed to the client. If the client loses coverage of MA, the client will be responsible for the full fee amount of session(s) not covered.

____Medicare:
Medicare typically pays the majority of the fee for service. The client will be responsible for any portion Medicare deems client responsibility; this typically includes any deductible and/or copay. MHA collects $15 per therapy appointment, and $20 per medication appointment to be placed towards these deductibles/copays and is due prior to services being rendered. Any outstanding balance will be billed on a monthly basis. If the client has a secondary insurance which provides payment towards the deductible/copay, or if there is an overpayment by the client, a refund will be issued to the client on a monthly basis.

____Sliding Scale: Current Rate _TBD_Evaluation _TBD_Therapy _TBD_Medication
The Mental Health Association provides services on a sliding scale for individuals who are uninsured. The cost of services will be established at the first visit, and all payments are due prior to services being rendered. Individuals are asked to provide paystubs/proof of current income every 6x months to determine correct charge for services.

____Private Insurance:
The Mental Health Association may not accept a client's private insurance. If this is the case, the client is responsible for the full cost of the session, and this payment is due prior to service being rendered.

Client Agreement:
I have reviewed this form, selected the correct insurance/payment coverage for the client, and agree to pay, as appropriate, any and all fees associated with my treatment while a client at the Mental Health Association. Each client is entitled to a billing statement upon request. I will inform the Mental Health Association of any significant changes to my financial and/or insurance plan information.

Client Name: ____________________________

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Client and/or Parent/Legal Guardian Signature Date

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Staff Signature Date