Service Agreement and Financial Policy

Name:_____ **Date:**_____

Identification Requirements:
Federal requirements require that we verify the identity of anyone presenting insurance. I understand that my identification and a copy of my insurance card may be scanned into my electronic file.

Fees and Insurance:
For those not using insurance the fees are as follows:

$140 per initial assessment hour for a psychologist
$120 per treatment hour for a psychologist
$120 per initial assessment hour for a counselor
$110 per treatment hour for a counselor
$50 per treatment hour for a group session

I understand that I am responsible for any and all fees incurred by me or a family member as a result of treatment provided by JFS of Richmond.

I understand that I am responsible for contacting my insurance carrier to see if outpatient mental health benefits are covered. I am responsible for obtaining any required referrals and authorizations prior to my visit. If I do not have a referral at the time of my scheduled appointment, I will be required to self-pay or reschedule. It is my responsibility to understand my plan's benefits.

If I am covered under an in network insurance plan that provides benefits for behavioral and mental health, JFS of Richmond will file a claim on my behalf. I understand that all applicable co-payments and co-insurance will be applied and payment is expected at the time of service.

Once insurance claims have be processed, if the amount collected at the time of the appointment is less than the amount that insurance determines is due, a monthly bill will be sent out that will inform me of the balance due.

Initial Page: _____

Payment is due within 10 days of receiving a bill. If my account remains delinquent, JFS of Richmond reserves the right to discontinue services until full payment is received or a payment arrangement has been made

JFS of Richmond also may refer my account to a collection agency if 60 days delinquent. In addition, I agree to be responsible for all costs of collection, including all attorney fees and court costs. If there was overpayment, JFS of Richmond will credit my account or refund me promptly.

I understand that insurance reimbursement is a contract between me and my insurance company. JFS of Richmond cannot accept responsibility for collecting a disputed insurance claim. If the claim is denied or not paid within 60 days, a bill will be sent to me and I am responsible for contacting my insurance company to research the reason and remedy. I am ultimately responsible for full payment on my account. Should I elect not to utilize my insurance policy for services rendered, I understand that I will be assessed the full fee and make payment at the time of service.

I understand that it is my responsibility to keep JFS of Richmond informed of my correct insurance information. If the insurance company I designate is incorrect, I will be responsible for payment of the visit at the rates listed above.

Providers do not testify in court on custody related matters or voluntarily become involved in court procedures. If you are in need of someone who provides court related services, we can help in locating someone. If my attorney or I subpoena a provider for testimony, I understand that I will be liable for a fee of $150/hour and travel time ($50/hour). Insurance does not cover this cost. This will be charged for all spent time in court and not just the time required to testify. This will be my responsibility, as insurance does not cover legal fees.

Assignment of Benefits:

I agree to allow JFS of Richmond to bill my insurance company for all psychological services, with payment paid directly to the agency by the carrier. I authorize JFS of Richmond to release any diagnostic/treatment information necessary to file a claim under any insurance policy through which I am covered.

Cancellation/ No Show Policy:

I agree to pay $50 for any no show appointments or for the cancellation of an appointment without 24 hours' notice. Insurance does not cover this cost. If I am insured with Medicaid, I will not be charged, but I agree to make every attempt to give proper notice.

Check Return Policy:

I understand that JFS of Richmond will charge $29 for any returned checks.

Confidentiality and Privacy Policies:

Please refer to the Notice of Privacy Practices for detailed information. Everything discussed in sessions is confidential. I understand that information about my case or my child's case will only be shared with my written consent, except under the following situations, as required by law:

- Imminent danger of harming self or others
- Suspicion of child or elder abuse or neglect
- Under a court order (efforts will be made to notify you of the request)

Client Signature
(Parent/Guardian)_____Date_____

JFS Witness _____Date_____