



Fees and Payment Policies – Medicaid

- Advance payments / account credits will be refunded if they do not apply towards any balance owing. _____
- Any service provided that is not a covered service by insurance will be client responsibility (i.e. records request). _____

Insurance Billing

- **Fees:** The intake fee is \$250.00. Both individual sessions and family sessions are \$175.00 per 50 minutes. Additional charges may apply (see page 2 of the disclosure information form). Your insurance will be billed for each session. _____
- I acknowledge that I have read and understood the Assignment of Benefits on the back of this page, which allows my insurance to pay ITSNW directly for services. _____
- **You are responsible for notifying us of any changes that affect billing, including your insurance coverage, subscriber name, or address. If you lose insurance coverage at any point you will be responsible to pay the fee for the non-covered sessions.** _____
- **Please chose one of the following (check & Initial):**

I attest that I am **ONLY** insured by Medicaid through Molina or Coordinated Care. _____

OR

I am also covered under a primary Insurance: _____
(Insurance Company name)

- I attest that I am not covered under Medicare. _____

Credit Card Exempt

- Molina clients covered under Apple Health or clients referred by a DSHS social worker (due to an open CPS case) who are covered under the CA contract are not required to give credit card account information. _____

Email for Invoices: _____
Emailed invoices may include patient information (name, DOB, etc.). By providing an email address, you are consenting to receiving invoices via email. Statements will still be sent via mail.

By signing below, I am indicating that I have read and understood the above terms and conditions.

Client Name: _____

Client Signature: _____ **Date:** _____

Guardian Name: _____
(if client is under 18 years old)

Guardian Signature: _____ **Date:** _____



(if client is under 18 years old)

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your mental health benefits is between you, the Health Care Authority, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO INTEGRATED THERAPY SERVICES NW, PLLC.

Signature of Responsible Party

Date

Name of Patient