**Fee Information, Payments, Cancelation Policy, and Managed Care Tips:**

Welcome to Compass Behavioral Health Clinic. We understand that searching for good counseling, including finding counseling agencies that are either affordable or that accept your insurance policy, can be a significant source of stress. Therefore, we work hard to keep our cost of services manageable, and, depending on circumstances, may be able to make arrangements to reduce the cost of services, so you can get the care you need.

**Psychiatrist and Nurse Practitioner**  **Mental Health Counselor**

$300: Initial Psychiatric Evaluation $190: Initial Evaluation

* Medication follow-up prices vary based $150 - $170: Individual Session

on duration of appointment $ 90: Group Session

**Psychologist:** **Addictions Counselor**

$210: Initial Appointment $190: Drug and Alcohol Assessment

$175 - $190: Follow-up Appts. $150 – $170: Individual Session

$750 for full Psychological Testing $90: Group Session

$45: Drug Screening (Breath and Urine)

Although many of our services may be covered by insurance companies, it is ultimately the responsibility of each consumer to ensure timely payment for services rendered. If you have a private insurance policy, please contact your appropriate representative(s) to determine if your policy will cover services offered at Compass Behavioral Health Clinic, as well as what your co-pays and deductibles will be. Co-payments will be due at time of service. If you do not have insurance, the full cost of the service rendered will be due before the service is offered.

Cancellation Policy

When it is necessary to cancel an appointment, you are expected to do so 24 hours in advance. Patients are responsible for 50% of the professional fee when an appointment is No-showed or late cancelled. Insurance companies will not reimburse for late cancellations or No-show appointments. Any patients who fail to abide by this policy risk termination with their doctor and/or therapist after two (2) missed appointments. Note that two No-shows and/or late cancellations in a six (6) month period may be cause for termination of treatment at Compass Behavioral Health Clinic. Patients will receive letters following a late cancellation or a No-show appointment reminding them of the clinic policies and advising them if they are being charged.

Please note that insurance companies often need sensitive clinical information (in this case, psychiatric assessment results, diagnoses, and treatment plans) in order to cover services rendered.

Our staff is obligated to protect the confidentiality of our consumers and will only give insurance companies information that is absolutely needed (with our consumers’ consents), so the services you participate in are covered adequately.

**Fee Information, Payments, Cancelation Policy, and Managed Care Tips Continued:**

1. My signature below signifies I have read and agree with Compass Behavioral Health Clinic’s fee and payment process (including acknowledging that the ultimate responsibility for payment is the consumer’s or responsible party’s), and that I understand and will comply with the cancelation policy:

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Consumer or Responsible Party Date

2. I hereby assign medical and psychotherapy benefits to which I am entitled (including Medicare, private insurance and/or other health plan benefits) to Compass Behavioral Health Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original copy. I hereby authorized said assignee (CBHC) to release all information necessary to secure payment on my behalf:

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Consumer or Responsible Party Date

3. By signing below, I accept responsibility for all charges not covered by my insurance company. This includes but is not limited to non-covered services, a covered service for which a prior authorization was denied or services that are not covered under my benefit plan or if my insurance changes and I neglect to inform Compass Behavioral Health Clinic. I also am aware that if my insurance does not cover Compass Behavioral Health Clinic, I am responsible for all charges incurred. The charges for such services are payable at the time of service. This agreement is valid for my entire course of treatment:

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Consumer or Responsible Party Date

Client Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_