CLATSOP BEHAVIORAL HEALTHCARE

65 N. Hwy 101, Suite 204 Warrenton, OR 97146
Phone (503) 325-5722 Fax (503) 861-2043
www.clatsopbh.org

Financial Agreement

(Effective 06/1/2018)

Client Name:_____ Date of Birth: _____

I understand that I am responsible for payment of all fees associated with my treatment at the time each session is held, unless an alternate arrangement is made or I have insurance coverage that requires another arrangement. I understand that non-compliance of the payment policy or failure to adhere to a payment plan may result in the suspension of services.

Standard Rates	MD	PMHNP	QMHP	QMHA
Case Management per 15 min.	$105	$80	$40	$35
Diagnostic Evaluation	$480	$440	$398	
Group Therapy per hour			$78-$92	
Group Therapy per 1-1/2 hour			$117-$138	
Group Therapy 2 hour			$156-$184	
Group Skills Training per hour			$40	$35
Individual or Family Counseling per hour			$324-$388	
Individual Skill Services per 15 min.			$40	$35

Insurance Information

Primary Insurance Company: _____ Phone:_____
Policy ID #: _____ Policy Group #: _____
Subscriber Name: _____ Subscriber Relationship to Client: _____

Secondary Insurance Company: _____ Phone:_____
Policy ID #: _____ Policy Group #: _____
Subscriber Name: _____ Subscriber Relationship to Client: _____

I understand that CBH will bill the standard rate to my Medicaid insurance carrier, if I provide valid proof of insurance. I understand that out of county Medicaid will not cover services for Clatsop Behavioral Healthcare and I will be responsible for paying for services received, or transferring my OHP to Columbia Pacific CCO.

- ✓ I authorize my insurance company to be billed and I authorize the release of any information necessary to process claims. I understand that court-ordered services may not be covered by Insurance and/or Medicare.
- ✓ I agree to pay any co-payment, deductible or any fee for services not covered by my insurance company. I understand that I will be billed for service, if the service is not covered by my insurance.
- ✓ I agree to provide copies of my insurance card and authorize CBH to keep a copy in my chart. If I do not provide proof of insurance to CBH, I understand that I will be responsible for paying for the services I receive.
- ✓ I agree that if my insurance lapses or changes, I will be responsible for notifying CBH and I will be responsible for any charges not covered.

My signature below attests my understanding and agreement to the above terms and conditions.

_____ _____

Client (or Parent/Guardian's) Signature Date