FAMILY GUIDANCE CENTER OF WARREN COUNTY

CLIENT AGREEMENT FOR SERVICE

Please read this form carefully. This Client Agreement for Services form requires your signed acknowledgement and agreement in order to receive services at the Family Guidance Center.

Our Goal and Philosophy:

The primary goal of The Family Guidance Center of Warren County is to provide quality evaluations, counseling and therapy services to Warren County residents based on their ability to pay. Payment for services rendered to clients is critical to allowing us to provide quality services. With the help of some limited public funds, we are able to offer an ability-to-pay allowance to offset a portion of the cost of services for clients unable to pay the standard fee. This reduction is based upon family income and family size. If this allowance still results in a significant hardship for you and your family, you may apply through your therapist for a further reduction in the amount you are expected to pay.

Cost for Services:

The standard cost for services at The Family Guidance Center is shown below. We will accept any applicable third-party reimbursement such as private insurance or public health insurance (Medicaid, Medicare). In addition, the Center receives funding from the State of New Jersey and Warren County which can be used to offset the cost for services to clients unable to pay the standard fee. Therefore, if your income qualifies you for our "ability-to-pay allowance", the portion of the fee for which you are responsible will be calculated upon your ability to pay. If you request an ability-to-pay allowance, proof of income is required at the time of intake (last month's pay stubs, last income tax return, entitlement program award letter). *With* the exception of Medicaid recipients, all clients are expected to pay their portion of the full fee. Clients with Medicare or insurance are expected to pay any applicable deductibles and/or their office co-pay at the time of each visit.

Fee Schedule:

(Client's printed name:)_________________________________'s expected payment is based on a total family income of $___________________and a family size of ______, resulting in an ability-to-pay allowance of _____________%.

SERVICE	STANDARD FEE
Family Therapy - full	$130.00
Group Therapy (90 minutes) per session	$ 50.00
Individual - brief	$ 75.00
Individual Therapy - full	$125.00
Individual Therapy - extended	$150.00
Intake Assessment- full	$175.00
Intake Assessment - extended	$250.00
Partial Care - Hourly	$ 25.00

SERVICE	STANDARD FEE
Psychiatric Evaluation	$450.00
Psychiatric Medication Visit (15 min)	$85.00
Psychiatric Evaluation and Management Visit (30 min)	$125.00
Psychiatric Evaluation and Management Visit (60 min)	$220.00
Injection	$25.00
UDS charges are billed by Clarity Laboratory/ Innovative Lab Solutions	

Client Agreement:

- If I miss a session or cancel it less than 24 hours prior to the session, I will be charged (the standard fee).
- I will make the expected payment at the time services are provided directly prior to treatment session.
- I understand that it is possible that insurance or other third-party reimbursement may result in lowering the amount expected from me. In the event that insurance reimbursement and my payments exceed the Center's standard fee, the Center will refund the difference directly to me.
- If an insurance payment is made directly to me, I will endorse the payment to the Center or reimburse the Center for the amount up to the full charge for services.
- If I have insurance and choose to request an "ability-to-pay allowance," I agree to apply for all insurance benefits for which I am eligible and- to provide the necessary insurance forms, including an assignment of benefits, to the Center. If I choose not to use my Insurance, or not to submit my claims through the Center, I will be responsible for paying the full charge for all services. I will notify the Center of any changes in my family income, family size or insurance coverage that could affect my responsibility for payment
- I agree to pay the established charge for checks returned for insufficient funds.
- I understand that if I fail to make payments for these treatment sessions, that no further treatment appointments will be scheduled until I make full payment or enter into a repayment plan to pay down any outstanding payment balance. If I fail to make such payments then my services with the Center will be terminated.

The information provided by me is accurate and truthful. I request an Ability-to-Pay Allowance" as Indicated on the front of this form. I understand my payment is due at the time of my visit and that the Center has the right to withhold treatment until payment is made.

Signature: ____Date: _______________________

Witness: ____