

FOUR COUNTY MENTAL HEALTH CENTER, INC.
 "Serving Montgomery, Wilson, Elk, and Chautauqua Counties"

DATE: _____

BILLING INFORMATION			
PATIENT NAME:		CASE #	
RESPONSIBLE PARTY FOR BILLING/INSURED PARTY:			
CARD HOLDER, IF DIFFERENT THAN RESPONSIBLE PARTY:			
RELATIONSHIP TO PATIENT:			
CARD HOLDER'S DOB:		CARD HOLDER'S SS#:	
CARD HOLDER'S PLACE OF EMPLOYMENT:			
CARD HOLDER'S ADDRESS:			
CITY:		STATE:	
CARD HOLDER'S PHONE:		ZIP:	

Four County Mental Health Center charges a per hour fee for services. However, you may be eligible for a fee discount based upon family income and the number of family members dependent upon that income. Proof of income is mandatory (paycheck stub, tax return, etc.). An hourly fee must be agreed upon before your appointment. Credit may be established by paying for the first three visits at the time of the visit. Credit is limited to five times your hourly fee. Proof of residency is required for State Alcohol/Drug supplemental funds.

HOUSEHOLD INFORMATION			
List all family members residing in the household. List all sources of income. (List additional family members on back if necessary)			
NAME	RELATIONSHIP TO PATIENT	GROSS INCOME	
NUMBER IN FAMILY:		TOTAL FAMILY INCOME:	\$

PAYMENT SOURCES - FOR OFFICE USE ONLY	
Includes private insurance, employee assistance programs, Medicaid, Medi-Kan and Medicare	
INSURANCE CARD ATTACHED	<input type="checkbox"/>
MEDICARE CARD ATTACHED	<input type="checkbox"/>
MEDICAID CARD ATTACHED	<input type="checkbox"/>
PRIVATE FEE ONLY	<input type="checkbox"/>
EAP COVERAGE	<input type="checkbox"/>
NAME OF COMPANY:	
OTHER:	

PROOF OF RESIDENCY	
YES <input type="checkbox"/>	NO <input type="checkbox"/>

IMPORTANT – READ CAREFULLY
<p>The patient or responsible party signing this form hereby certifies that the above information is complete and correct, and authorizes Four County Mental Health Center, Inc. to send information for billing as requested by payment sources. This information may include, if specifically requested, copies of the admission evaluation, treatment plans, discharge summary, clinical progress notes, and any other records produced by this agency. This authorization will expire upon completion of processing of my insurance claim and any subsequent requests or audits by the payment source, unless expressly revoked by me at an earlier date. I further understand that revoking my consent may result in my being responsible for payment of the claim and the above payment source(s) not being used.</p> <p>Based on the information furnished, Four County establishes a discounted fee of \$_____ per hour for mental health services, \$_____ per hour for alcohol/drug outpatient services and \$_____ per hour for psychiatric visits. Other fees may be established for different services provided at our agency. If the information furnished above is not accurate or complete, Four County reserves the right to demand and receive its undiscounted fee. If delinquent, this account may be sent for collection and any unpaid portion may show up on your credit report. Four County reserves the right to charge an additional fee of 10% to recover a portion of the collection costs.</p>

 PATIENT OR RESPONSIBLE PARTY SIGNATURE

 STAFF MEMBER SIGNATURE