

Fee Policy/Fee Agreement

All tasks on this page are to be performed by the Therapist, not the Secretary.

This form must be completed and updated annually if the sliding fee amount is set below the full rate. (A new fee agreement must be done before or during the same month that a case file was first opened the following year and the date the fee was set must be entered into the QSI system by the CSSW billing staff.) Each clinic's support staff will notify the CSSW billing staff of the date of the renewal and the fee amount each month for clients who have been receiving services continually for one year.

Two copies of this form are to be signed by the client or the client's parent/guardian if the client is a minor, at the first session. One copy stays in the file and the client keeps the other copy. Those clients who cannot legally sign this form – non-custodial caregivers – should be given a copy of the form for their information.

This form serves the following purposes:

- It informs the client of our fees
- It informs the client of policies regarding unexcused missed appointments, billing and payment
- It establishes a sliding fee amount
- It gives the client a format to sign their agreement to pay their portion of bills
- It gives the client a format to provide signed permission for release of information necessary to process insurance claims

Every client, without exception, must be assigned an established fee amount. This includes Managed Care, EAP, PPO, third party insurance, Title-19 (straight MA), MA-HMO and self pay clients. **Clients who decline to provide proof of income will be charged the full rate. If information is provided regarding income, a sliding fee amount can be set. All clients must sign this form.**

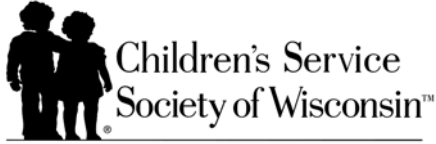
This form must be discussed with the client, and details explained:

- Make sure that the client and or the client's parent/guardian understands all information on the Fee Policy & Fee Agreement.
- Enter the name of the primary client, the household annual income before taxes and the number of persons dependent upon this income. A copy of the client's most recent tax return(s) or paycheck stub(s) must be attached to this form as verification of the household annual income.
- Use the sliding fee scale to establish a sliding fee amount and enter it on the form.
- The Therapist, with Director of Counseling approval, may assign a lower sliding fee amount for cases in which the client is unable to afford the calculated sliding fee amount**.
- If the client is a foster child, \$0.00 should be entered as the "annual income before taxes," and the "agreed upon fee based on income and number of dependents" should also be listed

as \$0.00. The “number of persons dependent upon this income” should be listed as “1” (i.e. the foster child).

- If a client has insurance coverage, remember to explain to the client or the client’s parent/guardian that co-pays and deductibles will not be reduced by the sliding fee scale, but can be set up as part of a payment plan, thus allowing them more time to pay their bill while still allowing us to bill their insurance. Discuss this with your supervisor.

****This may require that this form be mailed prior to the first session.**



A member of Children's Hospital and Health System.

2010

FEE POLICY & FEE AGREEMENT

This sheet contains important information about our policies and procedures. Please read it carefully. Ask your counselor to answer any questions you may have. Fees are charged for professional counseling service provided by Children's Service Society of Wisconsin according to the following schedule:

PROVIDER	INITIAL ASSESSMENT	ONGOING SERVICES	FACE -TO-FACE TIME CLIENT & CONSULTANT
Social Worker	\$187.50 per hour	\$150 per hour	Not Applicable
Psychologist (Ph.D.)	\$187.50 per hour	\$170 per hour	\$170 per hour
Psychiatrist (M.D.)	Not Applicable	Not Applicable	\$180 per hour
Group Therapy Clinician	\$187.50 per hour	\$75 per hour	Not Applicable

If you have Medical Assistance or private insurance we will bill your insurance company for services at the established rate. If you are covered by Medical Assistance, your co-payment will be billed to you following service. If your insurance does not pay in full, you will be responsible for the amount not paid by your insurance company. The Fee agreement does not apply to co-pays and deductibles since those rates are set by your insurance company. This Fee agreement only applies if you do not have insurance or if your insurance does not cover mental health services. It is up to the client to know what their insurance covers. CSSW will help verify coverage, but financial obligations are still the responsibility of the client. Should your coverage change or be denied by the insurance company you are responsible for paying for the services you or your child receives. If you do not have insurance, you will be responsible for paying the rate established on this fee agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you do not have insurance, or if your insurance benefits have been exhausted, your fee rate can be taken from a sliding fee scale that is based on income and number of dependents. In many of CSSW's offices, funding received through the United Way makes this possible. Proof of income is required to set the sliding fee amount below the full rates listed above. If you do not provide proof of income you will be charged the full amount. If you have Medicaid (MA) or have a Medicaid HMO, you will need to bring in proof of income in order to establish your sliding fee rate. This agreement is re-negotiable with loss of insurance or change in income or family size. It will be agreed upon at your first session. You will receive a monthly billing statement from our billing company. Payment is due within 30 days. Payment at each session is encouraged and appreciated.

Name of primary client	
Annual income before taxes (<i>If 2 or more earners, give total amount</i>)	
Number of persons dependent upon this income	
Agreed upon fee based on income and number of dependents	

REQUEST FOR FEE RATE CHANGE OR WAIVER: Provisions exist for reducing or waiving fees below the amount listed in the sliding fee scale. Please note that a request does not change your fee until the Director of Counseling approves the waiver.

MISSED APPOINTMENTS: With the exception of MA clients, if appointments are not canceled 24 hours in advance, you will personally be billed for the reserved time. You will be billed the amount established as your fee at the bottom of this agreement. You may request that the therapist waive this fee for a particular missed appointment based on unusual circumstances. You will be required to pay your fee prior to the next session if you have had two no shows/no calls.

I attest that the information provided above is true and agree to pay the established fee of \$_____.

I also authorize the agency to release any information necessary to process my insurance claims. I further acknowledge that this information has been reviewed with me and that I have received a copy.

Client or Parent/Guardian's Signature: _____ Date:

Therapist's Signature: _____
Date: _____