VALLEY | CITIES

FINANCIAL AGREEMENT

Client Name: _____ **ID#:** _____

Agreement to Pay: By signing this document, I agree to pay Valley Cities Counseling & Consultation (hereunder referred to as "Agency") all amounts due or to become due for services provided according to the terms of this agreement. I understand that I am financially responsible for any co-payments, co-insurance, deductible, or any charges not covered by my Third-Party Payor. I understand that all payments are due and payable at the time of service unless otherwise arranged with my service provider.

Sliding Fee Schedule: I understand that if there is no third-party coverage for services provided by the Agency, charges for services shall be determined by the Agency's Fee Schedule, which provides for a "sliding scale" of charges based upon my income and the number of dependents.

Third Party Payor (Including Medicare): I understand that I am fully responsible for payments of all services rendered. If services are covered by the Third-Party Payor, Agency will bill the insurance carrier or any other payors as a courtesy when I provide information on my coverage. I will pay Agency any charges not covered by the Third-Party Payor, and I will remit to Agency any payments received from the Third-Party Payor in relation to services provided by the Agency.

Medicaid: I understand that under most circumstances, my Medicaid coverage will be accepted as full payment for services provided and I will be expected to turn in a current Medicaid Coupon each time I receive services at the agency. If my coverage changes or is terminated, I will be held responsible for all charges incurred.

Consent for audio-only telehealth: I understand and consent to Valley Cities billing either myself or my health plan for an audio-only telehealth service. I am agreeing to this in advance of any audio-only telehealth services provided.

Loss of or Changes to Coverage: With loss of any medical coverage including Medicaid, I agree that I will be charged for all services based upon the sliding fee schedule and I will be responsible for payment of services unless alternative funding is available. I acknowledge that I am responsible for knowing the limits of my medical coverage.

Payment at Time of Service: I understand that all payments are due and payable at the time of service, and I understand that no services will be provided until payment is made in full.

Collection of Past Due Accounts: I understand that all unpaid accounts will be sent to collection, and no further services will be provided until the balance on my account is paid in full.

Appointment Cancellations: I agree to pay for missed appointments unless the appointment is cancelled at least 24 hours in advance. If I have Medicaid insurance only, I will not be charged.

Release of Information: I authorize the Agency to release any treatment or financial information necessary for payment to any third party, including an employer, insurer, payor, or government health program, who is or may be responsible for payment of all or any part of the Agency's charges.

Assignment of Benefits: I hereby assign to the Agency any rights to payment or reimbursement by any insurer, payor, plan, or government health program, otherwise payable to subscriber, to the extent of my account.

This form has been explained to me and I have read and understood its content. I understand that my signature on this document will be treated as a contract. If the terms of this contract are not met then the contract will be considered to be in default and my account may be referred to a collection agency, whereupon I agree to pay all costs incurred. I agree to contact Agency if my financial situation changes and to review my fee and payment schedule for possible adjustment. I understand that my agreement may be reassessed periodically. I also understand that Agency rates are subject to change with 30 days notice. I acknowledge receipt of a copy of this form.

Client	Date	Responsible Party	Date
Clinician	Date	Relationship to Client	Date

Signature of parent or legal guardian is required for minor clients.