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.

Valley|Cities

ADVANCE BENEFICIARY NOTICE

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

Your medical benefit may not pay for all of your health care costs. In order for services to be covered, the treatment must be determined by the payor to be "medically necessary" according to the payors respective standards and policies. The fact that certain services may not be covered under your medical benefit does not mean you should not receive the treatment. There may be a good reason your service provider recommended it.

Examples of non-covered services that your Medical Benefit may not pay:

- Exhausted benefits,
- Services provided beyond benefit limits,
- Authorization not received due to medical necessity criteria,
- Services provided by an out of network/non-preferred provider,
- Court ordered treatments,
- Case management services,
- Non disclosure or insufficient disclosure of full and complete billing information.

Other: _____

_____

_____

_____

If it is determined at a later date that the listed service is covered by your benefit then you will be refunded any payments made that are due to you.

I acknowledge that I am responsible for knowing the limits of my medical coverage. I have chosen to receive the described treatment furnished by VCCC even though it may not be covered by my medical benefit. I take full responsibility for payment of all fees in relation to the above treatment. I understand that I may be eligible for a sliding fee scale, based on my income.

_____ _____

Client Signature Date

_____ _____

Agency Representative Signature Date

Note: The purpose of this form is to help you make an informed choice about whether or not you want to receive the recommended services. Please ask for an explanation if you do not understand why your suggested treatment is not covered.

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OUTPATIENT FEE SCHEDULE

Client Name: _____ **ID#:** _____ ***Effective: January 1, 2024***

Scale	Discount	Adjusted Monthly Income		Flat Rate		Hourly Rate						
	%	From	To	*MH* Intake	SUD Intake	Dr/ARNP Services	Individual Services	Family Services	MH Group	SUD Group	SUD Case Mgmt	MH Case Mgmt
A	0%	5,290	and up	***300.00***	***475.00***	***450.00***	***275.00***	***165.00***	***160.00***	***70.00***	***200.00***	***150.00***
B	10%	4,842	5,290	270.00	*427.50*	*405.00*	247.50	148.50	*144.00*	63.00	*180.00*	*135.00*
C	20%	4,393	4,842	240.00	*380.00*	*360.00*	220.00	132.00	*128.00*	56.00	*160.00*	*120.00*
D	30%	3,945	4,393	210.00	*332.50*	*315.00*	192.50	115.50	*112.00*	49.00	*140.00*	*105.00*
E	40%	3,497	3,945	180.00	*285.00*	*270.00*	165.00	99.00	*96.00*	42.00	*120.00*	*90.00*
F	50%	3,048	3,497	150.00	*237.50*	*225.00*	137.50	82.50	*80.00*	35.00	*100.00*	*75.00*
G	60%	2,600	3,048	120.00	*190.00*	*180.00*	110.00	66.00	*64.00*	28.00	*80.00*	*60.00*
H	70%	2,152	2,600	90.00	*142.50*	*135.00*	82.50	49.50	*48.00*	21.00	*60.00*	*45.00*
I	80%	1,703	2,152	60.00	*95.00*	*90.00*	55.00	33.00	*32.00*	14.00	*40.00*	*30.00*
J	90%	1,255	1,703	30.00	*47.50*	*45.00*	27.50	16.50	*16.00*	7.00	*20.00*	*15.00*
K	100%	0**	1,255	-	-	-	-	-	-	-	-	-

****

Adjusted Monthly Income is calculated as the household gross Income less **$448.33** per any additional person in the household.

****

Consumer is responsible for all co-insurance or co-payments at the time of service

****

Third Party Insurance is always billed at VCCC established full fee

****

*** In keeping with Washington State administrative code, we offer a special $0.00 fee for consumers eligible for services who have incomes below the grant standards for the general assistance program.*

****

Adjusted Monthly Income & Sliding Scale calculation:

Gross Monthly Income: **(a)** _____

# of Dependents: **(b)** _____

Amount to be Adjusted: **(c)** **(b)*$448.33** _____

Adjusted Monthly Income: **(d)** **(a)-(c)** _____

Scale: **(refer to scale above)** _____

Discount: **(refer to scale above)** _____**%**

Client Signature: _____ **Date:** _____

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RECEIPT OF DOCUMENTS

By signing below, I certify that I have received:

- Valley Cities Consumer Handbook
- A clinical staff Disclosure Statement
- Valley Cities Notice of Privacy Practices
- King County Notice of Privacy Practices
- Washington State Publication What to Expect from your Licensed Counselor.
- Washington State Publication Mental Health Advance Directives, Information for Consumers (for clients 18+ and emancipated minors)

By signing below, I also acknowledge that I have read and understand my client rights.

Client Signature:	**Date:**

CONFIDENTIALITY

Generally, the information you pass on to a clinician is not discussed outside of your treatment team. Valley Cities will not disclose information that you have given unless:

- You sign a release of information authorizing us to disclose this information (parents of children twelve (12) and under are responsible for providing this permission).
- Your clinician thinks you are in danger of harming yourself or someone else.
- Your clinician has any reason to suspect a child, a developmentally disabled person, or an elderly person is being abused or neglected.
- The release of information is court ordered or otherwise legally required.
- Other reasons for release as allowed or required by law, specified in the Notice of Privacy Practices and the Washington Department of Health brochure What to Expect from your Licensed Counselor.
- Family members or friends cannot see or receive information about your records without a signed release. Your clinician cannot tell them anything without your written permission, but can listen to information they share or give them general information about mental illness and services that are available.

By signing this form, I acknowledge that I have read and acknowledge this information.

Client Signature:	**Date:**

CONSENT FOR TREATMENT

The information in this application and consent form is complete and accurate to the best of my knowledge. I give my permission to contact my Emergency Contact in the event of an emergency.

I request and authorize the staff at Valley Cities Counseling & Consultation to evaluate, treat or provide consultation to myself or to the individual named below of whom I am the parent or legally constituted guardian.

Client Signature:	**Date:**

---OR---

Parent/Guardian Signature:	**Printed Name:**
Relationship to Client:	**Date:**

All voluntary clients 13 years of age and older must sign that they consent.

VALLEY | CITIES

Behavioral Healthcare

COMPASSION. CONNECTION. COMMUNITY.

Telehealth Consent

By signing this document, I acknowledge:

1. I may refuse consent for telehealth services at any time without it affecting my right to continue services with Valley Cities. Valley Cities may discontinue telehealth services if those services do not appear to be a benefit to metherapeutically.

2. I will not share my telehealth appointment link or information with anyone who is not approved to attend the session. I understand that I am responsible to ensure privacy at my location and that Valley Cities will ensure privacy at their location. I am aware that confidential information may be discussed during a telehealth session.

3. I understand there are potential risks to using telehealth, including but not limited to, interruptions, unauthorizedaccess to the session, and technical difficulties. Valley Cities is not responsible for technical difficulties over whichthey have no control.

4. I will not record audio or video of any telehealth session. Valley Cities will not record a telehealth session unless Iam informed and provide written consent.

5. If I have questions about telehealth, I may discuss these with Valley Cities at any time.

I have read and understand the information provided above and I give my consent for the use of telehealth services.

_____
Signature of Client

_____
Printed name

_____
Date

VALLEY | CITIES
Behavioral Healthcare

CLINICIAN DISCLOSURE STATEMENT

Note: Your clinician will discuss the disclosure when they meet with you. Please wait to sign this form until after that discussion.

The disclosure statement for this service provider was given to and/or reviewed with the client today.

A copy of the disclosure was offered to the client. ___ YES ____NO

Client Signature: _____

Date: _____