Henrico Area Mental Health & Developmental Services

Financial Agreement

New Client	Revision or Update	Reopen

Client's Name:_____Last Name First Name Middle Initial Client's SS#: - - _____

Case #: _____ Program: _____

Insurance

If your insurance company covers services offered, you will be responsible for any deductibles, co-insurance and co-pays. If your insurance does not pay, you will be responsible for fees related to services received. **Co-pays are due at the time of service.**

Self-Pay (check all that may apply)

- o Residential Services or Day Services:
  I agree to pay total residential fees of $_____per month. I agree to pay total Day Services fees of $_____per month.
- o Individual Supported Employment and Behavioral Consultation.
  I agree to pay the per hour fee

ID/DS Patient Pay for Waiver Services

The Department of Social Services has assigned a Patient Pay of_____. HAMHDS as the provider will collect my Waiver Patient Pay. Individuals in Residential Services are assessed a fee for room and board which is 80% of annual income.
My annual income is $_____.

ID/DS Waiver Services I will receive include:

- o Behavioral Consultation
- o Day Services
- o Residential
- o Individual Supported Employment

Transportation services:

- o I agree to pay in accordance with the current transportation fee schedule based on the number of trips made per month.

1-15 trips = $15/month 16-29 trips = $27/month 30 and more trips = $45/month

Full Fee

- o I agree to pay full fee for the services received, in accordance with the agency's fee schedule

FLAT FEE SERVICES (check all that may apply)

___Anger Management Group-$80 - (8 Sessions)_____Custody Evaluation - $200_____Visitation Evaluation- $150
___Court Evaluation- $60 Court Evaluations are not eligible for a Fee Adjustment Request. If fees established would cause undue financial hardship the following options are available: Installment Payment Plans and /or Financial Fee Appeal.

FEE ADJUSTMENTS: If fees established would cause undue financial hardship the following options are available: Fee Adjustment Request, Installment payment plans, and/or Financial Fee Appeal. You may obtain more information regarding these options from your Case Manager, Clinician, or Business Office Staff. To be considered for any type of fee adjustment you must supply Income and insurance information.

- o **Fee Adjustment Request:** Based on the income information you have provided, you will be required to pay_____percent of charges or a minimum fee of $_____.
- o **Installment payment plan (without interest):** PREVIOUS BALANCE:_____**Payments** of $_____to begin _____.
- o **Fee Appeal:** Based on unusual and extraordinary expenses you are requesting instructions to apply for additional financial relief.
- o **No documentation:** Proof of income and insurance information is required to have a fee adjustment. You will be charged 100% of agency fees until income verification and insurance information is provided
- o Crisis Evaluation (Screening for TDO): The client is unable to complete the financial at this time. Do not bill client.
- o Crisis Evaluation (Screening for TDO): The client has no family member available to provide financial information at the time of service. Do not bill client.

I certify that the applicable financial and insurance information provided is accurate to the best of my knowledge and agree to the terms above. It is understood that if I fail to make any of the agreed payments at the time of service it will result in interruption of services. Henrico Area Mental Health & Developmental Services will pursue collection under the Commonwealth of Virginia debt set-off collection act for any outstanding balance.

Client/Responsible Party's Signature_____**Date**_____/_____/ _____

Responsible Party SS#_____

Completed By_____ Staff Code_____

FINANCIAL REVIEW

Case Number:_____ Date: _____

Name of Client:_____ _____ _____
Last Name First Name Middle Initial

Date of Birth of Client:_____/_____/_____ Client's SS#:_____-_____- _____

RESPONSIBLE BILLING PARTY INFORMATION

Name:
Last Name First Name Middle Initial

Address:_____Phone (H) (_____)_____Phone
(W) (_____)_____

_____ _____ _____ Relationshipa _____
City State Zip

SS#:_____-_____-_____

MONTHLY INCOME

Gross Wages:_____ Parents:_____

Unemp Comp:_____ SSI:_____

Disability/WC:_____Public Assist: General Relief:_____

_____Aid Interest/Div:_____

to Retirement/Pension:_____ From:_____

Dependent Children:___ Other:_____ From:_____

Alimony/Child Support Income:_____ SSDI:_____

Spouse:_____

Total Annual Income:_____

Financial Info Disclosed and Verified? 0 **Yes** 0 **No** **Assignment of Benefits Signed?** 0 **Yes** 0 **No**
(If no, select reason for unverified income)
Reason for Unverified Income? 0 **Refused** 0 **Pending** 0 **N/A**

ASSESSMENT

Family Size:_____ In Services?_____ Residential Fee: 0 Yes 0 No Monthly Amount:_____

Should this consumer be assessed on the short term slide? 0 Yes 0 No Expiration Date:_____/____/_____

Should this consumer be assessed on the long term slide? 0 Yes 0 No Expiration Date:____/____/_____

Slide %: Additional Slide %: _____ Total Slide %:

Additional slide approved by:_____ Expiration Date:_____/____/_____

Suppress Printing Statement? 0 Yes 0 No Statement Suppression Expiration Date:___/___/_____

Client Name:_____ **Case #:**_____
Last First MI

ASSIGNMENT OF HEALTH INSURANCE BENEFITS

I hereby authorize payment to Henrico Area Mental Health & Developmental Services of any health insurance benefits payable to me as a result of services provided by Henrico Area Mental & Developmental Services.

I also authorize Henrico Area Mental Health & Developmental Services to disclose information to my insurance companies and other third party payors for the purposes of reimbursement and coordination of care. I understand that my written permission is required for the disclosure of my substance use information to my insurance company and other third party payors.

I understand that I have the right to restrict disclosure of health information to my insurance companies and other third party payors for services I pay for out of pocket in full prior to the service being provided. The restriction will apply only if the disclosure is for purposes of payment or health care operations and the protected health information relates to a health care item or service for which I have paid HAMHDS in full prior to the services.

Employer ID# 54-6001344
Signature of Client or Responsible Party_____ Date_____

Name of Client or Responsible Party (Print)_____ Date_____

Relationship to client_____

For staff use when conducting financials in the Community or when providing Emergency Services:
Check the appropriate box instructing the billing office how to process billing for services provided.
___Insurance verify eligibility and bill
___Do not bill for crisis evaluation due to
___Client is unable to complete financial interview
___Family member is not available to provide financial information

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Permission to share Financial Information regarding my account

Financial information regarding my account may be shared with the following people.

Name_____ **Relationship**_____

Address_____

Name_____ **Relationship**_____

Address_____

Client Information: This permission shall remain in effect but, I understand that at any time I can submit a written request to revoke the above people from receiving information. I also understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

Signature of Client or Responsible Party_____ Date_____
Name of Client or Responsible Party (Print)_____ Date_____
Relationship to client_____