

CAPSTONE BEHAVIORAL HEALTHCARE, INC.

Financial Agreement and Insurance Information

Name _____ Date of Birth _____

Agreement to Pay:

- I understand that I am financially responsible to Capstone Behavioral Healthcare for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductibles stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- I understand that Capstone Behavioral Healthcare will not deny services because of an inability to pay the standard fee and that my fee is determined by verified income, family size and the State of Iowa approved fee schedule.
- It is my responsibility to inform Capstone Behavioral Healthcare of any changes that affect the billing or charges to my account. This includes changes in any of my third-party payors, income or family status.
- I understand that standard collection procedures will be followed if payment is not made.

Initial for above statements _____

Standard fees and charges:

- Mental Health Individual and Family therapy, 60 minutes: \$130.00
- Psychological Testing, 60 minutes: \$130.00
- Psychiatric Evaluation, 60 minutes: \$240.00
- Psychiatric Medication Management, 15 – 20 minutes: \$60.00
- Substance Abuse Evaluation/OWI Evaluation: \$100.00
- Substance Abuse Individual Therapy, 60 minutes: \$100.00
- Substance Abuse, Group Therapy, 60 minutes: \$35.00
- Mental Health, Group Therapy, 60 minutes: \$43.00
- Domestic Abuse Intake/Evaluation: \$80.00
- Urinalysis: \$20.00

Statement of Income:

- In order to be considered for a reduced fee I hereby certify that my weekly/monthly/annual **gross** family income is _____ for a family size (include self) of _____.
- If I qualify for reduced fees, I agree to **provide verification of income**.
- I agree to pay the established fee of _____%.

Client Signature Date

Staff Signature Date

(Continued)

Insurance Information

Primary insurance _____

Insured's Name _____ Insured's Date of Birth _____
Month / Day / Year

Insured's Address _____ Insured's Phone Number _____

City State Zip code
Insured's Social Security # _____ Gender Male Female

Insured's Policy # _____

Insured's Relationship to client Self Spouse Parent Other

Insured's Employer _____

Employer's Address _____

City State Zip code

Secondary Insurance _____

Insured's Name _____ Insured's Date of Birth _____
Month / Day / Year

Insured's Address _____ Insured's phone number _____

City State Zip code
Insured's Social Security # _____ Gender Male Female

Insured's Policy # _____

Insured's Relationship to client Self Spouse Parent Other

Insured's Employer _____

Employer's Address _____

I understand that having health insurance is not a guarantee that my condition is covered and that insurance payment will be made.

Assignment of Benefits: I authorize payment by my third-party payor (Insurance Company, Medicare/Medicaid, County, or other) to be paid directly to Capstone Behavioral Healthcare for services rendered. I understand that I am financially responsible to Capstone Behavioral Healthcare for charges applied to deductibles and for all charges limited by my third-party payor.

Signature of Individual Receiving Services/Legally Responsible Person Date

Staff Signature Date