THERAPEUTIC HEALTH SERVICES **Mental Health / Counseling Financial Intake Form**

For Department Use Only:

Program: ☐ MH ASSESSMENT ☐ MH TREATMENT ☐ PSYCH EVAL PROFILER ID:_____ Intake Date:_____

Branch: ☐ Rainier Branch (206) 723-1980 ☐ YFS Branch (206) 322-7676 ☐ YFS Everett Branch (425) 263-3006 ☐ Eastside (425) 747-7892 ☐ Shoreline Branch (206) 546-9766 ☐ Summit Branch (206) 323-0930 ☐ Seneca Branch (206) 323-0934

Funding: _____

Funding Change From: _____ To: _____ Funding Change Effective Date _____

Client Name: _____ Gender: ☐ M ☐ F
(Last) (First) (MI)

Guardian Name: _____ Gender: ☐ M ☐ F
(Last) (First) (MI)

Billing Address: _____
(Street) (City) (State) (Zip)

Marital Status: _____ Home Phone #: _____ Cel. Phone #_____

Date of Birth: _____ SS#: _____

Employer's Name: _____ Work Phone #: _____

Address: _____
(Street) (City) (State) (Zip)

* Insurance Co.: _____ Gross Monthly Income $: _____ Number of Dependents:_____

* Please fill out additional insurance paperwork.

A) MENTAL HEALTH ASSESSMENTS/PSYCHIATRIC EVALUATION:
There is a $125 flat fee for a mental health assessment. Psychiatric evaluations are charged based on hourly rate charged by THS. An assessment is payable by cash, money order, credit card, state funded Medicaid or low income. The agency Sliding Fee Scale is applicable to clients without any form of funding, and clients whose income and family size are eligible under the Federal Poverty Guidelines.

B) MENTAL HEALTH TREATMENT/COUNSELING SERVICES:
Treatment fees shall become the responsibility of the parent/guardian when clients are on Youth Family Services Program and/or are unable to pay for themselves. THS will accept Commercial Insurances as payers, however, clients or parents/guardians are responsible for deductibles, co-pays and non-covered services, if applicable. Clients statements are mailed monthly, and payment of the entire outstanding balance is due upon receipt of the statement. Failure to pay an outstanding balance on time shall be considered delinquent, and may result in suspension of future treatment services or immediate discharge from treatment. A payment plan contract is available on a case-by-case basis. Balances of discharged clients not paid in full within 180 days shall be turned over to a collection agency.

C) LOW INCOME TREATMENT DISCOUNT:
To qualify for a discounted rate (Sliding Fee Scale), a clients or client's parent/guardian must submit their most current proof of income, such as, but not limited to: unemployment invoice, pay stub. Retirement/disability benefits must be submitted on a monthly basis.

D) MEDICAID ELIGIBILITY:
THS checks Medicaid eligibility every month. However, it is the client or parent/guardian's responsibility to follow-up each month if their coverage needs updating, reviewing or re-applying for the coverage, as well as notifying THS on any changes in their coverage status.

E) NSF CHARGE:
$35.00 will be charged for each non-sufficient funds (NSF) check. Accepted replacement payment options include cash, debit cards, credit cards, manager's/cashier's checks and money orders. Personal checks are not accepted.

ACKNOWLEDGMENT

I, _____, understand the above terms of payment and that these terms may be subject to change. I further understand and agree that failure to pay my account as it becomes due may result in my/my child's termination from the program. Based on my financial information (provided above and by verification), I hereby acknowledge the following fees as applicable:

B) MENTAL HEALTH / COUSELING PROGRAM Fee Schedule					
$		Intake/Assessment	$		Case management per hour
		Individual Counseling per hour			Vocational Group
		Family Counseling per hour			Individual Therapy/Vocational
		Group Therapy/Adult Day per hour			Missed Appointment fee (1)
		Psychatric Evaluation per hour			Late Payment fee
		Medication Management		%	Sliding Fee Scale Discount**
		Special Population/Crisis Services			** A copy is available at Finance.

Signature: _____ Remarks: _____

Date Signed: _____ _____

Witness: _____ _____

(1) If not cancelled within 24 hours of appointment, missed appointment fee will be billed to the client.