SOUTHWEST IOWA MENTAL HEALTH CENTER

Charges for Services

Patient Name: ____

The full fee for services at the Southwest Iowa Mental Health Center is the cost to the Center for providing services. This is the amount charged to your insurance.

Charges for services provided at the Southwest Iowa Mental Health Center are as follows:

Service	Charge
Initial Evaluation (1.5 Hours)	$300.00
Therapy (1 Hour)	$200.00
Medication Management	$100.00

If you do not cancel or reschedule your appointment 24 hours in advance you will be charged a $25.00 No Show/Late Cancel Fee, for all insurance except Medicaid.

Health insurance may help cover the cost of your treatment, but you are responsible for your account. You may need to pre-authorize your care by calling the number on your insurance card before receiving services. Please present your insurance card at each visit and notify us of changes in coverage. Co-payments are expected at each visit, and you are expected to pay your balance prior to completion of treatment. Payment plans may be arranged. Medicare, Medicaid (Title XIX) and most health insurance carriers are accepted.

If applicable, your services may be supplemented by your county of residence. This will allow the possibility of a reduction in charges in the form of a sliding fee. The fee is based on your household size and household income. To be considered for a reduction, income verification <u>must</u> be provided for all members of the household that receive any type of income. If you do not provide income verification, you will be responsible for 100% of the charges for services.

I understand that should I fail to pay my fee as agreed, the Center may terminate services to me. I also understand that should I fail to pay my fee, my account may be subject to collection under the Laws of Iowa. In any proceedings to collect fees owed by me under this agreement, I authorize the Center to disclose such information necessary to make collection, and specifically waive any physician-patient or counselor-client privilege relating to that information.

I give permission to the Center to contact my insurance company with diagnostic and treatment information deemed essential to complete my claim. I understand the Center will bill my insurance company and any payments made on my behalf belong to the Center, and that any refunds due to me will be made when treatment is completed.

________________________________ ____________ ________________________

Signature of Patient or Responsible Party | Date | Witness