CENTER FOR FAMILY DEVELOPMENT
1258 High Street, Eugene, OR 97401 Phone: (541) 342-8437/Fax: (541) 342-1639

MENTAL HEALTH PROGRAM FEE AGREEMENT

Name: _____

I understand that my payer and/or payer arrangement with CFD is as follows:

- ☐ Self Pay
- ☐ Commercial Insurance
- ☐ Other: _____

I agree to and understand the following statements:

- Center for Family Development (CFD) will submit claims for services provided to the appropriate payers, and by signing this form I authorize such billing
- I will receive a monthly statement listing services, payments, and adjustments. The statement will specify an amount due from me, and I understand payment is due upon receipt.
- I understand charges for minors not covered by the payer will be billed to the legal guardian initiating services.
- I understand that CFD accepts payment by cash, check, VISA, or Mastercard.
- I understand it is possible that there may be additional costs incurred, related to counseling that cannot yet be determined.

Self Pay (if applicable)
Agreed amount per session: _____

Commercial Insurance (if applicable)

Payment for costs not covered by insurance are due at the time of service.

- I have the responsibility to contact my insurance carrier(s) to verify coverage and benefits.
- I will inform Center for Family Development (CFD) of any changes in my coverage as soon as possible.
- I am responsible for any cost that is not covered by my insurance carrier(s). This does not include any portion that is the contracted discount with the carrier(s).
- If I choose to exceed the number of visits my insurance carrier(s) has authorized, I will be responsible for payment of services exceeding the authorized amount.
- Unless otherwise specified by my insurance carrier(s) during CFD's initial benefit check, I understand that I will be responsible for paying an amount of $25 at the time of service until CFD receives further information from my insurance carrier(s).
- I understand that Commercial insurance does not pay for consultation or case management services, and I will be responsible for these costs if these services are provided.
- If CFD is out of network with my insurance carrier and/or if the insurance plan does not cover the service provided, I will be responsible to pay for any charges at the time of service. CFD will then reimburse me the amount paid by the insurance carrier.
- If I believe I may be covered by a secondary carrier and provide all necessary information of the secondary carrier, CFD will submit claims as a courtesy.

Other (if applicable)
Describe: _____

If applicable, I authorize billing to my insurance company and payment of medical benefits directly to CFD. I authorize CFD to provide information to my insurance company that is necessary to complete this billing process.

By signing below, I acknowledge that I have read and agree to the above fees and responsibilities.

Select One: ☐ I do NOT want a copy of this Authorization ☐ I am being provided with a copy of this Authorization

_____ _____
Signature Date CFD Representative Signature Date