**FEE DETERMINATION FORM**

Client Name:

Date of Birth:

Case #:

RESPONSIBLE PARTY:

_____ Self
_____ Parent
_____ Spouse
_____ CSB Custody
_____ Other: ______________________________________

If someone other than you is responsible, please indicate their name and address:

Name: _________________________________________________________

Address: _______________________________________________________

_____ MEDICAID (Copy of current Medicaid card must be provided.)

Medicaid Number: ___________________________________

Monthly Spend Down Amount: $_________________________

_____ MEDICARE (Copy of current Medicare card must be provided.)

Medicare Number: ____________________________________

_____ I acknowledge I will be responsible for coinsurance and/or deductibles required by Medicare, regardless of patient fee level. Initial below:

_____ WORKERS COMPENSATION (Copy of claim must be provided.)

Claim Number: ______________________________________

Effective Date: ________________________________________________

End Date: ____________________________________________________

_____ HEALTH INSURANCE (Copy of current insurance card must be provided.)

Insured's Name: _______________________________________________

Relationship to Patient: ________________________________________

Insured's Social Security #: _____________________________________

Date of Birth: _________________________________________________

Insureds Employer: _____________________________________________

Required Co-pay: ______________________________________________

Is patient also covered on any other insurance policy that might cover our services:

_____ No

_____ Yes (If so, complete the Supplemental Insurance Information Form.)

I acknowledge I will be responsible for copays if required by my insurance, regardless of patient fee level.

__________ Initials

I understand that it is my responsibility to ascertain from my insurance provider if coverage is available for the service(s) to be provided. The Counseling Center has not made any representations as to the amount to be paid by my insurance company.

__________ Initials

_____ Sliding Fee Scale Determination

__________ $ Gross Combined Family Income

__________ Number Supported on Income

__________ Patient Fee Level

**AUTHORIZATION TO BILL THIRD PARTY**

I, hereby, request that The Counseling Center bill the charges for any eligible services that I receive to the payors indicated above. I authorize payment of medical benefits to The Counseling Center for services provided. I also authorize the release of any medical information necessary to process this claim to the plan administrator or its authorized agent, if applicable, for the purpose of determining benefits payable in connection with my claim.
I understand that if my insurance, or other payors, do not cover the billed services, that I will be responsible for payment based on my adjusted fee; and that any insurance payments received by me will be forwarded to The Counseling Center.

Signature ______________________________________________ Date __________

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OFFICE USE ONLY: