Family Service
OF THE PIEDMONT

Name: _____	**D.O.B.**: _____
F.S.P.#: _____	
Medicaid #: _____	**IPRS / LME #**: _____

Agreement to Pay

By signing below I agree to pay for services I receive at Family Service of the Piedmont (including individual, couples, group and family therapy, and court appearances) according to the fee schedule or the per visit co-pay listed below. I agree that it is my responsibility to notify Family Service of the Piedmont of any change that may affect my payment. This may include, but is not limited to, change in income, change in insurance coverage, Medicaid or Medicare eligibility status, family size or other change that might affect my eligibility for benefits. Failure to notify Family Service of the Piedmont of such change may result in my being liable for 100% of fees for services provided by Family Service of the Piedmont.

Full fees are:

Comprehensive Clinical Assessment	$150.00
Individual, Family or Couples Therapy, per session	$100.00
Group Therapy, per session	$ 50.00
Court Appearances, per hour	$ 50.00

My co-pay, based on the information I have provided to Family Service of the Piedmont, will be $ _____ per visit. All payments are due prior to service provision.

My current payor is _____
My policy number is _____

Authorization to Collect Insurance. I authorize Family Service of the Piedmont to release information necessary to process payment claims for services provided by this agency. I authorize this agency to apply for benefits on my behalf for covered services rendered and request that payment be made directly to Family Service of the Piedmont. **I understand that it is my responsibility to notify the Finance Office of any change in my insurance coverage or benefits. I understand that I may be responsible for claims not paid for by my insurance company as a result of such change.** I understand this authorization is valid for the duration of treatment unless I choose to revoke this authorization. If I revoke this authorization, I understand that I can stop the release of information in the future, but that I cannot stop information already released. I also understand that if I revoke this authorization, I will be responsible for full payment of further treatment fees.

I understand I will need to present my insurance card at each visit.

_____ _____
Signature of Client, Parent or Guardian Date

_____ _____
Witness Date