**Fee Agreement**

**Patient fees dues at time of service:** **Standard fees for services:**

Deductible (per insurance) $\_\_\_\_\_ Assessment $170

Copayment per service (per insurance) $\_\_\_\_\_ 45-50 min Individual/Family Session $150

Payment per service $\_\_\_\_\_ Group Therapy 60-90 min $70

Administrative fee for missed copay $20 Lab urinalysis screen $70

Missed appointment/late cancel fee $50 Confirmation test for positive UA $15

Returned check fee $35

**Fees for services not covered by insurance, due at time of service:**

Rapid urine drug screen $25

Records request/copying fees .31 per page + postage

Written Reports/Forms $37 - $150

Court appearances, phone calls, consultation meetings $150 per hour

3% Late payment fee for accounts past due by 60 days

**Disclaimer:**

We verified your health insurance benefits as a courtesy to you. We cannot guarantee the accuracy of the information provided by your insurance company. We will collect payment from you based on the information they provided to us. However any remaining balance is your responsibility. I authorize my insurance carrier to pay benefits directly to Oakwood Clinical Associates.

**Payment options:**

1. Cash, check (electronically processed), debit or credit card at each appointment
2. Automatic monthly payment from bank account or credit card
3. Pre-payment on account for future services
4. Log onto [www.oakwoodclinical.com](http://www.oakwoodclinical.com) to make a payment by check or credit card
5. $20.00 minimum for all check and credit card payments required

**Payment assurance:**

1. Payment is due at time of service
2. Missed appointment/late cancel fee is due at next appointment
3. Written reports will be not be released until account balances are paid in full

**Patient responsibilities:**

1. Accept financial responsibility for all charges for myself and/or family members receiving services from Oakwood Clinical Associates.
2. Pay for services as arranged by one of the above payment options, missed payment results in cancellation of future appointments until administrative fee of $20 is paid.
3. Notify Oakwood office staff of any changes to income, residence or insurance status.
4. Arrive on time for appointments, tardiness to group results in a missed group and a fee of $50.

\_\_\_\_\_ EAP sessions approved at $0 patient responsibility. If you continue care beyond EAP benefit, above applies.

In the event an account is forwarded to our collection agency an administrative fee of $50 plus 30% of the account balance is charged.

I understand and agree to the above financial agreement for services provided by Oakwood Clinical Associates.

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­

Signature of parent/guardian/representative Printed name Relationship

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_