The Mountain Center
Fee Schedule and Payment Agreement

Assessment	$250
Individual Therapy, 1 hour	$225
Individual Therapy, 30 min	$115
Family Therapy, 1 hour	$200
Group Therapy, 1 hour	$45

Patient Name _____

I, _____, acknowledge that I have received the above fee schedule and agree to pay for all services rendered by therapeutic providers of The Mountain Center for myself or the patient named above.

I understand that:

- If possible, The Mountain Center will bill insurance for the patient's services.
- It is my responsibility to provide accurate and current insurance information.
- I may still owe a copay.
- If I do not have insurance which covers behavioural health services or if I do not provide accurate insurance information in a timely manner, I will be charged the above rates.
- If I do not have applicable insurance, I have a right to apply for a sliding scale fee schedule before I begin services.
- All charges for services not covered by insurance must be paid as soon as such charges are calculated. If you do not make payment (whether co-payments or other amounts) the patient's appointment may be rescheduled.
- Cancellations with less than 24 hours notice or no-shows will be charged a $25 fee.

If the patient has insurance, we will be happy to bill the insurance company as a courtesy. You must still pay the required copayment at or before the time of service, as well as any deductible and/or percentage not covered by insurance. We will try to answer any questions relating to insurance and will help the patient obtain from their insurance company any estimates for coverage. Please realize that Insurance is a contract between the patient, the insurance company and often the patient's employer. We are not a party to that contract.

Primary Insurance Information:

▢ Presbyterian	▢ United Healthcare	▢ Blue Cross Blue Shield
▢ Molina	▢Medicaid	▢ Medicare

Policy # _____
Insured's Name: _____
Insured's Birthdate: _____
Insured's SSN: _____
Insured's Address: _____
_____
Relationship to Patient: _____

Secondary Insurance Information:

▢ Presbyterian	▢ United Healthcare	▢ Blue Cross Blue Shield
▢ Molina	▢ Medicaid	▢ Medicare

Policy # _____
Insured's Name: _____
Insured's Birthdate: _____
Insured's SSN: _____
Insured's Address: _____
_____
Relationship to Patient: _____

I certify that the above is true to the best of my knowledge:

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Office Use Only
Fees are waived due to grant: _____ until _____(date).

Staff Signature: _____.