MUSKINGUM BEHAVIORAL HEALTH
FEE AGREEMENT

On this date, _____ , an agreement is made between _____ and Muskingum Behavioral Health.

Personal Income:	Household Income:
Total Income:	Number of individuals living in the household:

Method and responsibility for payment of covered services is (check all that apply):

_____ **Medicaid:** _____
(List type, and copay / responsibility, if applicable)

_____ **Medicare:** _____
(List type, and copay / responsibility, if applicable)

_____ **Commercial Insurance:** _____
(List type, and copay / responsibility, if applicable)

_____ **GOSH**: _____
(List type, and copay / responsibility, if applicable)

_____ **Client, and <u>I understand that I will be responsible for 100% of the cost of treatment</u>** (unless / until there is a time that I am eligible for financial assistance through local financial assistance, or gain insurance coverage to cover the cost of my services).

The rates below indicate the standard fee (full cost) of each service offered by Muskingum Behavioral Health. Your actual out-of-pocket cost will vary, depending on the level of financial assistance you receive, if any (based on your income), the insurance payers in your coordination of benefits, and other variables.

Activity	Code	Code Name	Unit	MBH Standard Fee	Current Medicaid & GOSH Reimbursement Rate
Assessment	90791	Assessment (16 - 90 Minutes)	Encounter	$157.00	$111.11
Assessment	90837	Assessment (91 - ∞ Minutes)	Encounter	$142.00	$102.31
Case Management	H0006	Case Management	15 MIN Unit	$24.00	$19.54
Group	90853	Group Therapy (Medicare and Commercial Insurance)	Encounter	$34.00	$28.12
Group	H0005	Group Therapy (Medicaid and GOSH)	15 MIN Unit	$12.00	$9.37
Individual Therapy	90832	Individual Therapy - up to 37 minutes	Encounter	$71.00	$53.64
Individual Therapy	90834	Individual Therapy - 38 - 52 minutes	Encounter	$95.00	$69.74
Individual Therapy	90837	Individual Therapy - 53 minutes or more	Encounter	$142.00	$102.31
IOP	H0015	Intensive Outpatient Group Therapy	Encounter	$180.00	$149.88
N/A	90785	Interactive Complexity (Add-on Code)	Encounter	$16.00	$11.74
N/A	99354	Prolonged Service (60 minutes additional time - Add-on Code)	Encounter	$136.00	$76.42
N/A	99355	Prolonged Service (each additional 30 minutes - Add-on Code)	Encounter	$104.00	$75.85
Peer Recovery Support Group	H0038: HQ	Peer Recovery Support - Group	15 MIN Unit	$3.00	$15.51
Recovery Coach Individual	H0038	Peer Recovery Support - Individual	15 MIN Unit	$19.00	$1.94
Urine Collection	H0048	Urinalysis Collection	Encounter	$18.00	$14.48

Last Updated: 12/11/2019

BY SIGNING BELOW,

I agree to **pay my amount due at <u>each visit</u> or time of service**. I understand that I must provide proof of income and a copy of my Medicaid or other insurance card (if applicable), otherwise I will be responsible for 100% of the service fees. I understand that if I **<u>do not make payment as expected</u>** that **services <u>may be suspended</u>**. I understand that, if I do not pay for services rendered, Muskingum Behavioral Health has the right to take legal action to obtain payment. A collection agency may be used to collect past-due fees and a service charge will be assessed.

Muskingum Behavioral Health will not deny services to anyone for the INABILITY to pay. Muskingum Behavioral Health does **<u>reserve the right to deny or discontinue services for REFUSAL to pay</u>** and to increase the copay / financial responsibility based on a failure to report accurate income or changes in personal, family, or total income. I understand that it is my responsibility to report changes in income, to provide proof of such changes, and to request to sign a new fee agreement.

CONDITIONAL WAIVER OF CONFIDENTIAL INFORMATION: I, the undersigned, agree that I am required to pay for services rendered to me by Muskingum Behavioral Health in accordance with the plan scheduled applicable to my case. I further acknowledge that all information divulged by me in counseling sessions is confidential information and will be retained and held confidential by Muskingum Behavioral Health, in a manner consistent with 42 C.F.R and HIPAA. I further acknowledge that in the event that I do not pay those co-pays charged me by Muskingum Behavioral Health for services rendered to me, that Muskingum Behavioral Health may be required to take legal action, including divulging to its attorneys and courts in the local, state, and federal systems, the fact that I do owe an account to Muskingum Behavioral Health. I specifically agree that in the event I have not made the payments required by me on my accounts, that Muskingum Behavioral Health may reveal the fact that I have an account with them, the amount owed on the account, the date(s) services were rendered and the amounts of time involved in rendering said services to its attorneys and courts in the local, state, and federal systems for the purpose of collecting said account.

Client Signature: _____ Date: _____

Parent or legal guardian signature (if applicable): _____

Employee Signature: _____ Date: _____