

## PAYMENT AGREEMENT

Client Name:

Name of Person(s) Accepting  
Responsibility:

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**Client Payments:** Payment/Copays are due at the time of service; this also includes teletherapy. Due to the nature of services provided and differences in insurance plans, ACGC is only able to provide an estimate of what you may owe. If we have not collected enough from you, we will bill you for the difference. If we collect too much, we will refund you within 60-days after your insurance has processed your claim. If ACGC pauses billing statements, (pandemic, system updates, etc.) you are still responsible for services rendered. ACGC offers payment plans and no one will be turned away due to an inability to pay. Contact ACGC's Revenue Cycle Manager if you need assistance.

**Late Arrivals, Cancellations and No-Shows:** For therapy to be useful, it must take place regularly. A \$10 fee will apply to all late cancellations and no-shows. If your arrival time is more than 15-minutes past your scheduled appointment, your appointment will be canceled and the fee will apply. To avoid any fees, please cancel 24 hours in advance of your scheduled appointment. The only exception to this policy is if your child is ill or contagious. Failure to pay these fees may result in therapy being paused or terminated.

**Insurance/Medicaid:** During the intake process, you must provide ACGC with a valid insurance card if insurance is to be used for services. If ACGC is contracted with your insurance, we will file your claims on your behalf. When using your insurance, you are authorizing and assigning payment to ACGC from your insurance for all billed services. Insurance may not cover the full amount, or any amount of the services received. You are responsible for understanding your insurance benefits and for paying any remaining balance after your insurance has processed your claims.

**Release of Information:** You authorize the release of medical records and treatment information to your insurance company for payment, continuity of care, medical billing, and health insurance billing. You may decide to pay out-of-pocket to keep records from being sent to your insurance company for privacy reasons related to mental health and/or substance abuse. If you choose this option, you will not be able to use ACGC's sliding fee scale.

**Non-Covered Services:** Child and adolescent groups, caregiver groups, workshops, and walk-in therapy services are not covered by insurance/Medicaid. Some plans do not cover extended-length or crisis visits, and not all diagnoses are covered by all plans. You agree to pay for these non-covered services out of pocket.

**Coverage Changes:** It is your responsibility to update ACGC with any changes/updates to your insurance information within 30-days of the change. If you lose insurance coverage, you will be responsible for paying for services received.



**Out-of-Network:** If the clinician you are seeing is not contracted with your insurance, you will be self-pay. To utilize out-of-network benefits, you must pay the full fee and then submit claims to your insurance plan. If you would like to use ACGC's sliding fee scale, you will be asked to sign an insurance waiver form agreeing not to submit claims to your insurance plan for out-of-network reimbursement.

**Self-Pay:** Self-pay is available to clients in the situations listed below.

- You have insurance, but ACGC is not contracted with your plan. Please see the Out-of-Network section above for details.
- You are receiving services that are not covered by your insurance plan.
- You have insurance but would prefer to pay out-of-pocket for privacy reasons. You will not be eligible to use ACGC's sliding fee scale. See the Release of Information section above.

**Sliding Fee Scale:** ACGC offers a sliding fee scale to clients paying out-of-pocket for services listed above. You will be required to provide your household size and income (from any parent/guardian(s) living in your household) to qualify for the sliding fee scale. You will be responsible for reporting changes in household income or size, and fees will be re-assessed at times.

**Grants and Other Programs:** Grant assistance may be available in specific and limited circumstances. You will be informed by intake if your services qualify for grant assistance.

**I have read and acknowledge my responsibilities for services rendered by Austin Child Guidance Center. I am responsible for payment to ACGC for services provided on behalf of named client.**

**Signature:**

**Date:**

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