Payment Contract for Services

Name(s) of client(s) receiving services:_____
Address:_____ City:_____ State: ___ Zip: _____

Person responsible for payment (if different):_____
Address:_____City:_____State:____Zip:_____

Federal Truth in Lending Disclosure Statement

A. Clients With Insurance Coverage

1) Some insurance companies have incorporated your Social Security number as a part of your ID number. Please check your card to see if this is required and fill in your full ID number here.
2) Insurance Carrier:_____
   Full ID Number:_____Group #/Acct#:_____
3) Deductible amount: $_____
4) Co-payment: % or $_____
   We suggest you confirm your benefits and eligibility with you insurance company. The person responsible for payment is required to make payment for services that are not covered by your insurance policy (including all co-payments and deductibles). Note: Your insurance company may not pay for services that they consider non-efficacious, not medically or therapeutically necessary, or ineligible (when not covered by your policy and when the policy has expired or is not in effect). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services may be discussed with individual therapists. It is your responsibility to know if the desired therapist is accepted by our insurance.

B. Clients Without Insurance Coverage

I (we) agree to pay **Victoria Mental Health Services, Ltd.** a rate of $_____per clinical unit (defined as 45-50 minutes for assessment, testing, and individual, family, and relationship counseling).

C. All Clients: Please read and sign below

Payments and co-payments are due at the time of service. Any amount due on the client's account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement. I authorize **Victoria Mental Health Services, Ltd.** to disclose case record (diagnose, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly **Victoria Mental Health Services, Ltd.** I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires.

By signing below, I agree that I have received, read, and agree to the conditions of this form including the Federal Truth in Lending Disclosure Statement for Profession Services.

_____Date:_____
Signature of person responsible for payment