Client Payment Agreement

JNG Health Network seeks to provide quality therapeutic services to children, adolescents, adults, and older adults at an affordable cost. All clinical interventions, including psychological evaluations are provided according to clients' therapeutic needs. JNG Health Network has designed a sliding fee scale, which takes into consideration family size, to assist clients whose income brackets meet criteria for income-sensitive accommodation. On a case-by-case basis, JNG Health Network also encourages and supports the rendering of pro-bono services. The fee scale below is an outline of the therapeutic services offered and their estimated costs.

Therapeutic Services

Service Type	Service Time-Frame	Full Cost of Service	Sliding Fee Scale Income less than $40,000.00
Intake Assessment	60 – 90 minutes	**$150.00**	$100.00
Individual Therapy	50 – 60 minutes	**$130.00**	$75.00
Family Therapy	50 – 60 minutes	**$130.00**	$75.00
Couple Therapy	50 – 60 minutes	**$130.00**	$75.00
Group Therapy	50 – 60 minutes	**$50.00**	$30.00

Note: Services exceeding the allotted time by 30 minutes or more will be charged a ratio of the service cost accordingly.

Psychological Evaluations

10% discount may apply to low income individuals & families

Type of Evaluation	Assessment Tools	Cost of Service
Brief Assessment	- Clinical Interview - Review of Previous Records	$200.00 ~ $300.00
Immigration Disability Evaluation	- Clinical Interview - Review of Medical Records - Intelligence Test - Academic Achievement Test - Immigration Application Form	$500.00 ~ $700.00
Brief Psychological Evaluation	- Clinical Interview - Review of Previous records - 1 Projective & 1 Objective Test - Brief Intellectual Evaluation	$400.00 ~ $500.00
In-Depth Psychological Evaluation	- Clinical Interview - Review of Previous records - 2 Projective Tests & 2 Objective Tests - Brief Intellectual Evaluation	$600.00 ~ $800.00
Psycho-Education	- Clinical Interview - Review of Previous records - Intelligence Test - Achievement Test - Test of Visual-Motor Skills	$600.00 ~ $700.00
Neuro-Psychological, Personality, Mental Retardation, Vocational Evaluation, & Other Psychological Tests	- Assessment tools based on need	$150.00/face-to-face hour

Miscellaneous Services			
Service Type	**Service Cost**	**Service Type**	**Full Cost of Service**
Court Attendance	$350.00/Hour	Consultations	$100.00/Hour
Travel	$75.00/Hour	Trainings	Varies

Payment Agreement: Self-Paying Clients

The terms of the payment agreement between JNG Health Network and clients are listed below:

1. All payments must be paid at the point of which services are rendered.
    a. It is important to note that each service is estimated to last a set time frame. Services exceeding the allotted time will be charged accordingly in increments of 30 minutes.

2. Preferred methods of payments are credit cards, check, money order, or cashier check made payable to JNG Health Network. Cash payments are also accepted.

3. Clients with one or more "bad checks" will have to give a retainer for the services based on the number of sessions prescribed by their Clinicians.
    a. Bad checks are defined as any check that was returned due to insufficient funds or cancelled by client.
    b. Clients can pay a retainer voluntarily if desired

4. JNG Health Network, reserves the right to seek out the assistance of collection agencies, in an attempt to collect outstanding debt owed for services.

5. All clients requesting sliding fee scale or pro-bono services must provide proof of income and proof of the financial circumstances that warrant such accommodations.

6. Once service is completed, payments are not refundable. However, clients are encouraged to speak with the Clinical Director or the Executive Director of JNG Health Network if they are dissatisfied with services provided. Please refer to the grievance procedure in your "*Clients' Rights & Responsibilities*" form.

Payment Agreement: Health Insurance Companies & Other Third-Party-Payers

1. All clients receiving services funded by their insurance plan or Other Third-Party-Payers will comply with their rules and regulations as well as the ones outlined in this agreement as applicable.

2. All co-pays assigned by the insurance company or Other Third-Party-Payers must be paid at the point of which services are rendered.
    a. Preferred methods of payment are checks, money orders, cashier checks, and credit cards. Cash payments are also accepted.

3. Any conflicts with collection of payment from insurance companies or Other Third-Party-Payers will be addressed directly with them.
    a. All clients are responsible to inform JNG Health Network of any changes in their health care plans or changes in their relationship with the Other Third-Party-Payers.
        i. If failure to do so results in a lack of cooperation between JNG Health Network and the insurance companies, or Other Third-Party-Payers the client will be held responsible for the cost of service at the rate agreed upon with the said company.

b. JNG Health Network, reserves the right to seek out the assistance of collection agencies, in an attempt to collect outstanding debt owed for services that were not covered by the insurance companies or Other Third Party Payers.

4. Sliding fee scale and pro-bono services are not available for such clients.
   a. Once the allowable number of sessions covered by the insurance plan or Other Third-Party-Payers is exhausted, the client can then be considered for the sliding fee scale or pro-bono criteria.

Proof of Income (needed upon request for sliding fee scale or pro-bono services):

☐ Most Recent Income Tax Return ☐ Pay Stubbs for the past 3 months

☐ Other (Specify): _____

☐ **Self-Pay Clients:**

I_____ understand that I am obligated and responsible for the cost of:

$_____Per Unit of _____

$_____Per Unit of _____

$_____For _____

☐ **Health Insurance Companies & Other Third-Party-Payers:**

I_____ understand that _____ is responsible for all payments of services rendered to me and that I will be liable for:

$_____Per Visit as co-payment

$_____Per _____ as co-payment

☐ I _____ authorize JNG Health Network to bill my Health Insurance Company or Other Third-Party-Payers for the services provided to me. I understand that the billing for such services can be done via internet, mail, fax, e-mail, or by phone using form CMS 1500, JNG Health Billing Form, or other billing forms.

Identified Persons	Print Name	Signature	Date
Client			
Partner / Other Participant			
Parent/Legal Guardian			
Parent/Legal Guardian			
Person/Entity Responsible For Payment (If not Cient or Legal Guardian)			
Witness			