JNG HEALTH NETWORK
Your Choice for Quality Therapeutic Services

Client Payment Agreement

At JNG Health Network, we provide quality therapeutic services to children, adolescents, adults, and older adults at an affordable cost. We cooperate with all insurance providers in order to make payment for services more affordable and accessible to everyone we serve. JNG Health Network strives to be open and honest about all costs of services at onset, and accommodate Clients' financial needs whenever possible. Clients are informed of their financial responsibilities prior to initiating the services. Consent to proceed is obtained by completing and signing the payment agreement. The fee scale below is an outline of the therapeutic services offered and their estimated costs.

Therapeutic Services		
Service Type	**Service Time-Frame**	**Cost of Service**
Intake Assessment / Clinical Interview	60 – 90 minutes	**$150.00 ~ $300.00**
Individual, Family, & Couple Therapy	50 – 60 minutes	**$130.00 ~ $200.00**
Group Therapy	60 – 120 minutes	**$55.00 ~ $100.00**
Note: Services exceeding the allotted time by 15 minutes or more will be charged a ratio of the service cost accordingly.		
Psychological Evaluation		**Cost of Service**
Brief Assessment, Immigration Disability Evaluation, In-Depth Psychological Evaluation, Psycho-Education, Neuro-Psychological, Personality, Suitability to Parent, Mental Retardation, Vocational Evaluation, & Other Psychological Tests		Price Vary: **$130.00 ~ $300.00** Per Hour of Testing, Scoring, & Reporting

Miscellaneous Services & Charges			
Service Type	**Service Cost**	**Service Type**	**Service Cost**
Medical Record Request Processing Fee	$15.00	No Show / Cancellation / Rescheduling Fee	$30.00
Brief Letters of Recommendations	$75.00	Treatment Summary & Recommendations	$150.00
Court Attendance	$300.00/Hour	Consultations	$150.00/Hour
Travel	$75.00 each-way Dade & Broward	Trainings	Varies

20% discount may apply to low income individuals & families

Payment Agreement: Self-Paying Clients

1. All payments must be paid just prior to the beginning of services.
    a. It is important to note that each service is estimated to last a set time frame. Services exceeding the allotted time by 15 minutes or more will be charged accordingly.

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 be required to give a retainer for the services based on the number of sessions prescribed.

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 clients must provide only their ***Primary Insurance*** information. Secondary Insurances do not cover mental health services.

3. All co-pays, co-insurance, or deductibles assigned by the insurance company or Other Third-Party-Payers must be paid prior to or at the time of which services are rendered.

    a. Preferred methods of payment are checks, money orders, cashier checks, and credit cards. Cash payments are also accepted.

4. It is important to note that Health Insurance Companies & Other Third Party Payers may not pay the full cost of service. Any additional cost will be discussed prior to initiating the services and agreed and signed upon accordingly.

5. 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 Health 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 Health Insurance companies or Other Third Party Payers.

6. Sliding fee scale and pro-bono services are not available for clients whose services are being reimbursed by a Health Insurance company or Other Third Party Payers.

    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.

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.

Estimated Client Payment Responsibility:

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

$_____ for each session of Individual, Family, Couple, or Group Therapy, and/or Psychological Testing.

$_____ **Co-payment** for each session of Individual, Family, Couple, or Group Therapy, and/or Psychological Testing.

$_____of **Co-Insurance** / **Share-Cost** for the Clinical Interview

$_____of **Co-Insurance** / **Share-Cost** for each session of Individual, Family, Couple, or Group Therapy, and/or Psychological Testing

$_____ of **Deductible** for each session of Individual, Family, Couple, or Group Therapy, and/or Psychological Testing.

$_____ for **EAP** services consisting of Individual, Family, Couple, or Group Therapy, and/or Psychological Testing.

No-Show / Cancellation / Rescheduling Fee:

At JNG Health, every time slot is dedicated to service. Once an appointment is made, that time is dedicated to you and no other client. To enhance the quality of service you and others receive, a **24-hour** cancellation notice is required. This notice can be done via a phone call (954-404-7052 or 305-724-8040), text message (305-724-8040), email (**clientcare@jnghealth.com**), or by fax (954-435-5982).

Failure to cancel your service within the 24 hours and failure to appear for your scheduled appointment will result in a No-Show / Cancellation Fee of $30.00.

After two (2) no-shows / cancellations, the services will considered for termination.

Records Request Processing Fee

In compliance with HIPPA guidelines and the Florida Board of Psychology, all request for clinical psychological records are processed timely with the appropriate consent forms. To assist with the time and energy needed to facilitate all request for clinical psychological records, a small fee of ***$15.00*** is imposed. Clients are responsible to process this payment at the time of request.

Credit Card Authorization

I _____ Date of Birth _____ authorize JNG Health Network to charge my credit card, medical charge card, or debit card, in order to facilitate payment for the cost of my mental health service or the mental health service of my child, whose name is _____ and those not covered by Insurance or Other Third Party Payers, and the cost of co-payments, no-show/cancellation fee, share-cost, co-insurance, or deductibles, just prior to initiating the service.

For services that exceed $500.00, I agree to a payment plan where $_____ is withdrawn every _____ weeks until the balance is paid in full.

- *An invoice with the charges will be sent prior to charging the credit card on file.*

Primary Charge Card:

☐Visa ☐Mastercard ☐American Express ☐ Discover ☐Medical Charge Card

Name on Card:		Email address:	
Address:			
Card #:		Phone #:	
Expiration Date:		Security Code:	

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			