Metropolitan Behavioral Services

"Helping you to live in your reality"
4741 Atlantic Blvd. Ste. C Jacksonville, Florida 32207
Phone: 904-562-1391 Fax: 904-374-3057

PAYMENT CONTRACT FOR SERVICES

Name(s): ____
Address: ____
Bill to: (Person responsible for payment of account)**:** ______________________________
Address: ____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

PART ONE - FEES FOR PROFESSIONAL SERVICES:

I (we) agree to pay **Metropolitan Behavioral Services**, hereafter referred to as the clinic, a rate of
$140 per clinical counseling session,
$285 for Psychiatric Evaluation
$150 for Follow up/ Medication Management for psychiatry appointments.

****A FEE OF $45 IS CHARGED FOR MISSED APPOINTMENTS CONSIDERED AS NO SHOW OR CANCELED WITH LESS THAN 24 HOUR NOTICE! ****

PART TWO - CLIENTS WITH INSURANCE (DEDUCTIBLE AND CO-PAYMENT AGGREEMENT)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services.

1. If you have not met your yearly deductible, there may be a patient responsibility. Insurance companies will apply it to your "In Network Deductible" therefore making it your (the patient) responsibility to pay the remaining balance.
2. **All** Co Payments are to be paid prior to seeing the Therapists and/or Psychiatrist. (**NO EXCEPTIONS**)
3. Your insurance company may not pay for services that they consider to be not efficacious, not medically, therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services).
4. If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

PART THREE - ALL CLIENTS

Payments, copayments, and/or deductible are due at the time of service. There is a 1% per month (12% annual percentage rate) interest charge on all accounts that are not paid within 60 days of the billing date.
I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person (s) Responsible for the Account: ____

Person Receiving Services: ____

Parent or Guardian (if applicable): ____

Date Signed: ____________________/____________________________/_____________________