WESTERN MONTANA
MENTAL HEALTH CENTER

CONTRACT FOR PAYMENT OF SERVICES

Please read this fee agreement carefully and ask for any needed clarification. Please initial at the side of each statement and sign at the bottom.

By initialing each area, I attest that **I UNDERSTAND:**

_____ (initial)
1. I agree to pay any and all costs not paid by a third party payer. These costs may include: my deductible, co-insurance, and/or denial of coverage. If I do not wish to have my services billed to a third party or my insurance becomes inactive during treatment, I will be responsible for **payment in full.**

_____ (initial)
2. If I have Medicaid, I agree to pay any co-pay established by Medicaid. I understand that if my Medicaid becomes inactive during treatment or a service is not covered by Medicaid, I will be responsible for **payment in full.**

_____ (initial)
3. If I have Medicare, I understand that Medicare covers some but not all specific services offered by WMMHC. I agree to pay any co-pay established by Medicare. I understand that, if my Medicare becomes inactive during treatment or a service is not covered by Medicare, I will be responsible for **payment in full.**

_____ (initial)
4. I may qualify for public funding in order to offset a portion of my treatment costs. In order to qualify, I must provide proof of income. **I understand if I do not provide the necessary documentation of eligibility, I will not qualify for public funding and will be responsible for payment in full.**

_____ (initial)
5. In the event I do not qualify for public funding, I may be eligible for sliding scale fee services on the basis of my family income and number of dependents. In order to qualify, I must provide proof of income and complete an application. If I do not wish to provide the necessary documentation, I understand I will not qualify for sliding scale fee services and will be responsible for payment in full.

_____ (initial)
6. If my check is returned, I will be charged a returned check fee of $25.00.

_____ (initial)
7. If my income, situation, insurance coverage, address, or phone number changes, I will immediately notify WMMHC.

_____ (initial)
8. In the event I fail to pay fees as agreed upon, my account may be referred to a collection agency and/or law firm. If the event my account is sent to a collection agency and/or law firm, I will be liable for all costs associated with the collections process, including legal and demand costs.

_____ (initial)
9. I understand WMMHC cannot carry patient balances over 12 months from the last date of service. In signing this agreement, I agree to have the balance of my account paid in full within one year unless other arrangements have been made with the Accounts Receivable Department.

_____ (initial)
10. I understand this contract applies to any and all services rendered by WMMHC program and locations.

Client/Guardian Signature: _____ Date:_____

Client/Guardian Printed Name:_____

Staff Signature:_____ Date:_____