Payment Policy & Fee Agreement

Name: _____

Please read this agreement carefully and initial each box confirming that you understand.

Thank you for selecting **JEWISH FAMILY SERVICE OF THE DESERT** for help with your personal concerns.

_____**I understand** payment is due at the time of each date of service (DOS) and can be made by cash, check or credit card.
_____**I understand** JFS also accepts reimbursement from many third party payers, including Medicare and Medi-Cal. JFS may assist me in the completion of the necessary insurance forms to facilitate collection of benefits. **However**, I understand that I am ultimately responsible for all charges not covered by my insurance.
_____**I understand** that I must notify JFS when I change insurance plans or HMO providers as this change can modify or interrupt my mental health benefits. Failure to do so may result in requiring me to assume responsibility for payment of my counseling until a new authorization for treatment is approved.
_____**I understand** I may be charged $25.00 when an appointment is cancelled with less than 24 hours advance notice, or when I have failed to keep the appointment.
_____**I understand** that 2 or more late cancellations or "no shows" within 6 months may be cause to discontinue services, see "Cancellation & Late Cancellation Policy Reminder Notice" on back of this form.
_____**I understand** that if I have a deductible that has not been reached or if my insurance deems JFS to be an "out of network provider". JFS will offer me the following options, one of which I accept:

_____a) Pay full fee of $110.00 per DOS until deductible is reached.

_____b) Pay an out of network fee based on my insurance.

_____c) Pay a fee determined by the **JFS** sliding fee scale based on my gross monthly income (and that of family members living in the household), and not use my insurance.

ALL FEE CLIENTS MUST BRING PROOF OF INCOME TO THEIR FIRST SESSION. Service may be postponed without proof of income or payment. It is the policy of this agency to conduct an annual review of all fees. You will be asked for current proof of income at that time. My gross monthly income is _$_____.

_____**Insurance Client:** I have read, understand and agree to the **JFS** fee policy and I agree to pay whatever amount my insurance responsibility is, including but not limited to copay established as _$_____ on this date_____; this amount may change as verified/confirmed by **JFS** at later DOS.
_____**Fee Client:** I have read, understand and agree to the **JFS** fee policy and agree to pay a fee of $_____ for each DOS, based on the gross monthly income reported above.

_____ _____
Client Signature (Parent/ Guardian if client is minor) Date

_____ _____
Therapist Signature Date

_____ _____
Clinical Director Signature – ***fee clients only*** Date

Jewish Family Service is a beneficiary of the Jewish Federation of Palm Springs and Desert Area,
The United Way of the Desert and a member of the Association of Jewish Family and Children's Agency

Las t Revision 7/13/15

JFS CANCELLATION & LATE CANCELLATION POLICY REMINDER NOTICE

Our goal is to provide quality counseling in a timely manner. In order to do so we have a 24-hour cancellation policy. The policy enables us to better utilize available appointments for our clients in need of therapy.

Scheduling Appointments
We encourage clients to proceed to the front desk window after their session to schedule their next appointment. If you are not able to schedule your next appointment directly following a session, you may call the Palm Springs or Palm Desert office for scheduling. In an effort to avoid cancellations, only 2 appointments may be scheduled in advance.

Cancellation of an Appointment
We recognize that schedules sometimes change. If you must cancel your appointment, we require that you please call at least 24 hours before your appointment. Appointments are in high demand. Your early cancellation gives others the possibility of meeting with their therapist.

Late Cancellations
Cancellations made less than 24 hours before an appointment are considered a late cancellation. A fee of $25 may be charged if applicable. Excessive late cancellations may be cause to temporarily suspend or discontinue services.

No-Show Policy
A client is considered a “no-show” if they do not call either the Palm Springs or Palm Desert office to cancel the session nor arrive for the session. No-shows are inconvenient for both clients who need to schedule appointments and office staff and therapists who work hard to prepare for your visit. After a “no-show” has occurred, the client will be sent a letter reminding them to cancel appointments promptly if attendance is not possible. Also, the late cancellation fee of $25 may apply. After two “no-shows”, services may be temporarily suspended or even discontinued. In order to reinstate therapy services, a client will need to discuss the appointment attendance issue with their therapist.