Lighthouse
Dual Diagnosis Treatment, Education & Prevention Programs

Payment Contract

Payment Contract for Services

Name(s) of client(s) receiving services: _

Address: _____ City: _____ State: _____ Zip: _____

Person responsible for payment (if different): ___

Address: _____ City: _____ State: _____ Zip: _____

Federal Truth in Lending Disclosure Statement

A. Clients with Insurance Coverage

B.

1) Some Insurance companies have incorporated your Social Security number as a part of your ID number. Please check your card to see if this is required and fill in your full ID number here.

2) Insurance Carrier: _____

Full ID Number:_____ Group Number:_____

Subscriber Name: _____ DOB: _____

Please note if the *member ID* is the same for everyone listed on the plan we will need the *subscriber name* and *DOB* in order to submit a claim to your insurance provider.

3) Deductible amount: $ _____

4) Co-payment: % or $ _____

We suggest you confirm your benefits and eligibility with your insurance company. The person responsible for payment is required to make payment for services that are not covered by your insurance policy (including all co-payments and deductibles). Note: Your insurance company may not pay for services that they consider being not efficacious, not medically or therapeutically necessary, or ineligible (when not covered by your policy and when the policy has expired or is not in effect). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services may be discussed with individual therapists. It is your responsibility to know if the desired therapist is accepted by your insurance.

B. *Clients without Insurance Coverage*

I (we) agree to pay Northland Counseling Services a rate of:
$ _____ per Lighthouse chemical health diagnostic assessment
$ _____ per Lighthouse mental health diagnostic assessment
$ _____ per Lighthouse individual/family session
$ _____ per Lighthouse group session

C. *Driving with Care® Clients*

I understand that my fees must be made in full prior to successful program completion. I agree to pay Northland Counseling Services a rate of:
$200 per Driving with Care® Level I Program
$325 per Driving with Care® Level II Program
$35 per individual sessions

D. ***All Clients: Please read and sign below***

Payments and co-payments are due at the time of service. Any amount due on the client's account will be issued a statement showing the balance. Statement charges are due within 15 days. There may be an interest surcharge posted to overdue accounts which will be included on the statement.

I authorize Northland Counseling Services to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to Northland Counseling Services.

I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires.

By signing below, I agree that I have received, read, and agree to the conditions of this form including the **Federal Truth in Lending Disclosure Statement** for Professional Services.

_____ Date: ____/____/_____
Signature of person responsible for payment