Jewish Family Services of Richmond

Service Agreement

_____ _____

Client Name (Please print) Date

I understand that JFS of Richmond's fees for psychological services are as follows:

$140 per initial assessment hour for a psychologist
$120 per treatment hour for a psychologist
$120 per initial assessment hour for a counselor
$110 per treatment hour for a counselor
$50 per treatment hour for a group session

I understand I am responsible for any and all fees incurred by me or a family member as a result of treatment provided by JFS of Richmond. If I am covered under an insurance plan that provides benefits for behavioral and mental health, JFS of Richmond will file a claim on my behalf. All applicable co-payments and co-insurance will be applied and payment is expected at the time of service. I understand that JFS will file an insurance claim as a service to their clients and should not be considered an expectation or a substitute for my financial responsibility to the agency. If the insurance company fails to pay for the services, I understand that I am responsible for the payment, in full, immediately upon receipt of a statement from JFS. In addition, I agree to be responsible for all cost of collection, including all attorney fees and court costs. Should I elect not to utilize my insurance policy for services rendered, I understand that I will be assessed the full fee and make payment at the time of service.

TERMS OF PAYMENT

_____I agree to make payment for services rendered by JFS of Richmond on the same day of service. JFS will charge $29 for any returned checks. JFS reserves the right to cancel services in the event the terms of this agreement are not met.

CANCELLATION / NO-SHOW POLICY

_____I agree to pay $50.00 for any no show appointments or for the cancellation of an appointment without 24 hours notice.

ASSIGNMENT OF BENEFITS

I agree to allow JFS of Richmond to bill my insurance company for all psychological services, with payment paid directly to the agency by the carrier. I authorize JFS of Richmond to release any diagnostic/treatment information necessary to file a claim under any insurance policy through which I am covered.

_____ _____

Client Signature (Parent/Guardian, if minor) Date

JFS Witness:_____ Date:_____