AGREEMENT TO PAY FORM—STANDARD FEE SCHEDULE

I, _____ , assume financial responsibility for me and my dependent(s) treatment at Nutley Family Service Bureau, Inc. and agree to the following:

1. Fees and Payments

I understand that my insurance company will be charged the following rates for the services listed below. I then am responsible for paying any copays, coinsurances, deductibles or balances not covered by my insurance. Should I fail to provide all insurance information necessary to process my claim or should I elect to proceed as a self-pay client (meaning I decline to provide information regarding all available insurance coverages available to me) then I understand that I will be fully and solely responsible for the fees/rates as disclosed below, without benefit of an insurance claim

Intake Evaluation	*$200*	*Family Session*	*$150*
Individual Session	*$150*	*Family Session w/o Client*	*$150*

2. Outstanding Balance(s)

NFSB policy states that fees are due at the time services are provided. Balances may not exceed $150, and if a balance does accrue, I must show a good faith effort to pay the balance by arranging a payment plan with the NFSB accountant and make all payments according to that plan. If I do not make a good faith effort to pay the balance or meet my plan commitments, NFSB may terminate my treatment, or that of my dependent(s), and I will be responsible for all balances owed. This will be discussed with me in person or I will be notified in writing, before any treatment is suspended and/or terminated.

3. Method of Payment

I understand when paying fees, the fees must be paid for with cash, credit, or debit card. NFSB does not accept personal checks for standard office visits.

4. Remitted Funds

If I have an insurance plan which covers mental health services, I authorize NFSB to receive direct payment from my insurance company and I will be fully responsible for any copays, coinsurances, deductibles, or other outstanding balances not covered by my insurance for any reason. If my insurance company requires any pre-certifications, I will obtain all such information including copay, coinsurance, and/or deductible amount needed, prior to my first office visit. If my insurance company mistakenly sends to me any payment intended to cover treatment at NFSB, I will immediately forward such payments to NFSB. I understand that if my insurance company has denied a claim/claims and NFSB has exhausted their efforts. I then, am responsible for following up with my insurance company and remain responsible for any outstanding balance. Suspension and/or termination of treatment may result if payment is not forwarded to NFSB. This will be discussed with me in person or I will be notified in writing, before any treatment is terminated.

5. Cancellation Fee

NFSB policy states that I must arrive within 20 minutes of my scheduled appointment time or call NFSB to cancel my appointment at least 24 hours before my appointment is scheduled. If I arrive 21 or more minutes after my scheduled appointment time or do not notify NFSB of the cancellation at least 24 hours in advance, I agree to pay a fee of $25 for that missed appointment. The phone number is (973) 667-1884, prompt 1 for the Psychotherapy Center.

Primary Insurance Carrier:_____

Group Number:_____ **Identification Number:**_____

Name of Primary Insured:_____

Relationship to Primary Insured:_____

Secondary Insurance Carrier:_____

Group Number:_____ **Identification Number:**_____

Name of Secondary Insured:_____

Relationship to Secondary Insured:_____

WITH MY SIGNATURE BELOW, I AFFIRM THAT I HAVE READ, UNDERSTAND, AND AGREE TO NFSB's AGREEMENT TO PAY POLICY.

Printed Name of Client:_____

Printed Name of Financially Responsible Party:_____

_____

Signature of Financially Responsible Party (must be over 18 years of age) Date

☐ I agree that this agreement may be electronically signed. I agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____

NFSB, Inc. Representative Signature Date