COMPASS Behavioral Health Clinic
TRANSFORMING LIVES
1820 Center Ave. Ste. 170 • Janesville, Wisconsin 53546
Phone: (608) 755-1475 • Fax: (608) 755-1733

Business Policies

Service Fees

Services	Cost For Insurance	Self-Pay Fees
Therapists		
Initial Evaluation	$190	$175
Individual Session	$150-170	$90
Group Session	$90	$35
Nurse Practitioner		
Initial Psychiatric Evaluation	$300	$200
Medication Management	$200	$120

Please Note, clients who are self-pay will be charged half of self-pay rate for Late Cancelations and/or No Shows.

Fees NOT Reimbursed by Insurance Companies

Services	Fees
Late Cancelation/No Show Appointments	
Nurse Practitioner	$87.50
Therapists	$85
Group	$45
Court Preparation and/or Testimony	$200
Consultation or Other Services	$250
Third Party Record Requests	
Administrative Costs	$26
Copying Fee per page	$0.59

Cancelation Policy:

CBHC provides reminder calls regarding upcoming appointments. Ultimately it is the client's responsibility to keep appointments. If it is necessary to cancel an appointment, clients must provide at least 24 hours' notice. If staff is unavailable, clients are asked to leave a detailed message including client name, provider's name, reason for cancelation, and client phone number. If clients provide less than 24 hours' notice, or do not present for scheduled appointment, they are subject to Late Cancelation/No show fees noted above. Clients will receive letters following a Late Cancelation or a No Show appointment as a reminder of clinic policies and statement of any Late Cancelation or No Show fees. Three Late Cancelation and/or No Shows in a three month consecutive span will result in discharge from services.

Note to Guardian(s) or Personal Representative(s):

It is clinic policy to accept a guardian's or personal representative's signature on these forms as an agreement to be responsible for client's services with CBHC. In separated or divorced families, the person who initiated services with CBHC is held financially responsible. CBHC will not bill another person or estranged spouse unless that individual informs CBHC, in writing, of their willingness to pay for services rendered. Guardian(s) and/or Personal Representative(s) must attend the initial session with the client. If only temporary guardianship or representation has been issued, the client's biological parent must sign all paperwork and releases. No minor with a guardian and/or personal representative will be treated until status has been verified.

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Insurance and Billing Information:

Clients are encouraged to contact their insurance carrier to determine individual benefit package, as insurance policies vary. Clients are responsible for notifying CBHC staff if their insurance has terminated and/or changed. Although many of CBHC services may be covered by insurance companies, clients are ultimately responsible for all non-covered services.

Insurance Consent:

- I authorize release of information to all my insurance companies.
- I understand that I am ultimately responsible for my bill.
- I authorize my provider(s) to act as my agent in helping me obtain payment from my insurance companies.
- I assign insurance benefits and authorize my insurance company to make payments directly to CBHC.

Please note that insurance companies often need sensitive clinical information (in this case, psychiatric assessment results, diagnoses, and treatment plans) in order to cover services rendered. CBHC staff is obligated to protect the confidentiality of our clients and will only provide insurance companies information that is absolutely needed to ensure services are covered adequately.

Payment:

Payment of client deductible, co-payment, or self-pay fees are to be made at the time of service.

My signature below attests my acknowledgement of and consent to the following:

- I have read and agree to Compass Behavioral Health Clinic's (CBHC) fees, policies and payment process. I acknowledge that the ultimate responsibility for payment is the client's or client's Guardian or Personal Representative.
- I understand and will comply with CBHC cancelation policy
- I assign medical and psychotherapy benefits to which I am entitled (including Medicare, private insurance and/or other health plan benefits) to CBHC. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original copy. I authorize said assignee (CBHC) to release all information necessary to secure payment on my behalf.
- I accept responsibility for all charges not covered by my insurance company. This includes, and is not limited to, non-covered services, a covered service for which a prior authorization was denied, services that are not covered under my benefit plan, and/or if my insurance changes and I neglect to inform CBHC. I also am aware that if my insurance does not cover CBHC, I am responsible for all charges incurred. The charges for such services are payable at the time of service.
- I understand that the established policies and fees written in this form may be subject to change, and if changes are made I will be provided 90 days' notice.
- This agreement is valid for my entire course of treatment.

_____

Client Name (Printed):

_____

Client Signature Date

AND if applicable:

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Signature of Guardian or Personal Representative Relationship to Client Date

Revised Date: December 2021