Family Violence Prevention Center
GREENE COUNTY

Domestic Violence Intervention Program
BILLING AUTHORIZATION, RATES OF SERVICE, CONSENT TO TREAT

To be eligible to receive public funds (for example, Medicaid) to help pay for the cost of your Mental Health or Alcohol/other drug services, you must read and sign this form to allow your billing information to be entered in to the agency's Electronic Health Record, Therapy Notes.

Protected Health Information (PHI) will be used to verify your insurance status with the state. If you are determined to be eligible for Medicaid or other public funds, Family Violence Prevention Center (FVPC) will submit billing information necessary to obtain payment for treatment/services rendered. Billing information may include PHI, but not be limited to: your name, address, phone number, social security and / or Medicaid number, date of birth, gender and marital status, and type and quantity of treatment/services rendered.

Insurance Provider: _____ **Policy Number**: _____

If Receiving Medicaid, see Negotiated Rate section below.

If not receiving Medicaid, complete the following:

Individual Income:_____

Current Rates of Service:

Psychiatric Evaluation without medication:	$111.11 per session (one per year)
Individual Counseling	**30 min**: $53.64; **45 min**: $69.74; **60 min**: $102.31
Group Counseling	$21.63 per 1 hour session

Medicaid Negotiated Rates:

Psychiatric Evaluation w/out	$15.00 per session
Individual Counseling	$5.00 per each 30, 45, 60 minutes
Group Counseling	$5 per each session

Cash Negotiated Rates:

Psychiatric Evaluation w/out	$80.00 per session
Individual Counseling	$25.00 per each 30, 45, 60 minutes
Group Counseling	$25.00 per each session

ALL INFORMATION COLLECTED WILL BE KEPT CONFIDENTIAL and consistent with state and federal law. Billing information will only be kept up to seven (7) years after you have received services, and only demographic information will be kept after that time**. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.**

I understand that my records are protected by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR 2.12 (d) (2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations:

If you do not agree to sign this consent for treatment, the **Family Violence Prevention Center** may not be able to use public funds to pay for your services.

Client's Name (print): _____

Client/Guardian Signature: _____ Date: _____