Wellmore
Behavioral Health
Wellness for a lifetime™

Outpatient Program Fee Agreement

Client's Name: _____ Client's ID#: _____

It has been determined based on the information provided to us that the following fee agreement is applicable to the services that will be provided by Wellmore, Inc.:

Outpatient Services and Medical Provider's Services

Medicaid Coverage

☐ **Husky A, T-19 – No Fee**

☐ **Husky B - $10 copay/service**

Commercial Insurance Coverage

Ins Co. _____

☐ _____**Deductible,** _____**Copay/Coins. Amt**

Medicaid w/Commercial Coverage

Ins Co. _____

☐ **Husky A, T-19 – No Fee**

☐ **Husky B - $10 copay/service**

No Insurance

☐ _____ **% of each visit**

Gross Household Income _____

# of Household Members _____

☐ **temporary status until verifiable insurance information provided** **** must be received within 15 days or status becomes permanent and the balance becomes the responsibility of the client/guardian.

I agree to pay this amount in full according to arrangements agreed upon above.
I agree to notify Wellmore of any changes in my insurance benefits or financial status immediately.
I understand that any changes will void this agreement and a new agreement will be required.
I agree to make payment at time of appointment.
There will be a $20 fee for returned checks
I have been provided with a copy of the published rates

Guardian's Signature: _____ **Date:** _____

Guardian's Printed Name: _____

Witness: _____