Grand Island Mental Health
& Medical Clinic, LLC

**FINANCIAL HARDSHIP SLIDING SCALE APPLICATION**

| **Current Fees:** | |
|---|---|
| Initial Session with Diagnostic Assessment - $180.00 | 60 Minute Individual Session - $185.00 |
| 45 Minute Individual Session - $145.00 | 30 Minute Individual Session - $100.00 |
| Family Session - $120.00 | Substance Abuse Evaluation - $275.00 |

**Insurance Billing:**
We are happy to bill your insurance company or payor source on your behalf. Check with the front desk staff to be sure the provider who is treating you is in-network with your insurance company. If you have a secondary insurance company, we will send claims for payment to your secondary insurance upon receipt of Explanation of Benefits from your primary insurance company. Any remaining balance will be your responsibility to pay in full in a timely manner. We ask that you inform our office as soon as possible of any insurance coverage and/or eligibility changes. Failing to do so may result in a charge of the full billed amount. Copay amounts will be collected at the time of service.

**High Deductibles:**
If you have a high deductible plan or have not met your deductible yet, we ask that you pay $50 at the time of your visit to ensure that your account balance does not get too large. Once you have met your deductible, you will no longer be asked to pay $50 for each session at the time of service and the amount due at time of service will reflect your copay and/or coinsurance amounts set by your insurance company. If insurance happens to pay the entire amount for your session or you have a credit on your account, this amount will be reimbursed to you.

**Prompt Payment:**
Payment is asked for at the time of service unless other arrangements have been made. Past due accounts will be sent to collections if no payment arrangements can be made. Returned check fee is $25.00.

**Sliding Scale For Therapy:**
We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give you a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. **Unlicensed Intern**: Adjusted gross income X .001 = Rate of session with no amount being less than $50 or higher than regular session rate. **Licensed**: Adjusted gross income X .001 = Rate of session with no amount being less than $100 or higher than regular session rate. (Ex: $45,000 per year = $45/session, $95,000 per year = $95/session)

**Sliding Scale For Medication Management:**
We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give you a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. **First/ Intake session:** Adjusted gross income X .001 + 70% = Rate of session with no amount being less than $100 or higher than regular session rate. **An established client**: Adjusted gross income X .001 + 70% = Rate of session with no amount being less than $85 or higher than regular session rate. (Ex: $95,000 per year = $161.50/session)

2815 S. Locust Street, Grand Island, NE 68801
Phone: 308-398-0350 Fax: 308-398-0351 Text: 308-225-6464
www.grandislandmentalhealth.com - grandislandmentalhealth@gmail.com

Grand Island Mental Health
& Medical Clinic, LLC

***If you have any questions regarding this information, please feel free to ask your provider or front desk staff.***

## Financial Hardship Sliding Scale Application

**For Therapy**

We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give you a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. Household adjusted gross income X .001 = Rate of session with no amount being less than $50/ $100 or higher than regular session rate. (Ex: $45,000 per year = $45/session, $95,000 per year = $95/session)

Client Name: _____
Client Birthdate (XX/XX/XXXX): _____
Adjusted Gross Income:_____ x .001 = _____ = Session Rate: _____

*One form of income verification must be attached to this application

**For Medication Management**

We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give you a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. Household adjusted gross income X .001 + 70% = Rate of session with no amount being less than $85/ $100 or higher than regular session rate. (Ex: $95,000 per year = $161.60/session)

Client Name: _____
Client Birthdate (XX/XX/XXXX): _____
Adjusted Gross Income:_____x .001 = _____+ 70% = Session Rate: _____

*One form of income verification must be attached to this application

If I have insurance coverage, I have selected to not use my insurance for my treatment. I understand that opting out of using my insurance means I must pay out of pocket for my treatment. I agree to give notice if I either obtain alternative insurance and/or decide that I would like my sessions billed to my insurance. I understand that if I opt out of using my insurance I cannot use the payment of sessions towards my deductible because I have elected to opt out of using my insurance. I understand that if I choose to later use my insurance, my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance. My opt-in to use insurance will start from the day I notify my therapist of the change and cannot be backdated to previous sessions.

I do hereby affirm that the information provided on this application and income verification is true and correct to the best of my knowledge and understanding. I agree that any misleading, falsified information, and/or omissions may disqualify me from the Financial Hardship program. This could also subject me to penalties under federal law for falsifying information. I further agree to inform Grand Island Mental Health & Medical Clinic, LLC if there is a significant change in my income. I hereby acknowledge that I have read this information and understand it in its entirety. Any questions have been answered.

Client Name: _____

Client Signature: _____ Date:_____

2815 S. Locust Street, Grand Island, NE 68801
Phone: 308-398-0350 Fax: 308-398-0351 Text: 308-225-6464
www.grandislandmentalhealth.com - grandislandmentalhealth@gmail.com