



FA: _____ EFF: _____ CLIENT RU: _____ STAFF INITIALS: _____

Client Name: _____
First MI Last Social Security Number Birth Date

Lifeworks NW Fee Collection Policy:

If a client has a co-pay/co-insurance or is paying "out of pocket" they are subject to the agency fee collection policy. This policy also includes clients that have a payor resource who is making payments directly to the client for services provided or clients who have lost their insurance/payor. Clients who meet the criteria for the fee collection policy are required to pay at the time of service. Failure to pay may result in being suspended from treatment. Clients are not allowed to carry a balance for more than one session without being placed on a Balance Payment Agreement. Clients who fail to pay in a timely manner or who do not uphold their Balance Payment Agreement may have service suspended until payments resume.

I have carefully read, or have had read to me, all of the information above and I fully understand this information.

Please Initial: _____ **Date:** _____

Financial Responsibility (person(s) responsible for any payment of services received that insurance does not pay, for any reason. Responsible person must be present to sign fee agreement)

Name: _____ Phone: _____ Relation to Client: _____

Address: _____ City: _____ State: _____ Zip: _____

Responsible Person's SSN: _____ Birth Date: _____ Financially Responsible Initials: _____

Insurance Payor Information - Please check and complete all that apply.

Oregon Health Plan

Clients enrolled in a managed care plan under the Oregon Health Plan will not be charged for any services covered by Medicaid fee-for-service or through contracted managed care plans, except clients who have lost their insurance/payor or have any coinsurance, co-payments, and deductibles expressly authorized by the General Rules, OHP Rules or individual provider rules.

ID# _____ Medical Plan: _____ Mental Health Plan: _____

Medicare ID# _____ Supplement/HMO Name: _____

Commercial/Private Insurance

I understand that the information below is an ESTIMATE of my insurance coverage. My payment may increase or decrease depending on the amount reimbursed by my insurance company. If I have a deductible remaining, I agree to pay the full fee until that deductible is met. Additionally, I agree to pay any balance remaining after my insurance has paid or denied a claim. If my insurance company reimburses me directly, I understand that it will be my responsibility to pay in full and may be subject to collection if I do not pay. **Please Initial:** _____ **Date:** _____

Primary Insurance: _____ Secondary Insurance: _____

Co-pay/Co-Insurance amount: \$ or % _____ Deductible Remaining: _____

Worker's Compensation/Personal Injury Claim: Claim #: _____ Agency: _____ Phone: _____

DUII Program - Please ask the front desk for a list of current self-pay fees

Private Pay: Gross Monthly Income \$ _____ Number of Claimed Dependents: _____ Sliding Scale Tier: _____
Please ask the front desk for a list of current self-pay fees

I have carefully read, or have had read to me, all of the information above and I fully understand this information. If I am requesting that my health insurance pay for the treatment, they are likely to request information regarding my treatment, as well as itemized statements of charges. By signing this Fee Agreement I am authorizing LifeWorks NW to bill my insurance and authorize them to release the minimum necessary information to the insurance company as needed to be paid.

Electronic/Verbal Financially Responsible Signature

Date

For Office Use Only: Grant/Other Funding

- WaCo General Fund
- MultCo General Fund
- SUD/MTF

- Clackamas General Fund
- WaCo Gambling

Other:

LWNW CCBHC Sliding Fee Eligibility Grid
Effective 7/1/21

	Tier A	Tier B	Tier C	Tier C	Full Fee
Family Size	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income	
1	\$0 - \$1,073	1,074 - 1,610	1,611 - 2,146	2,147 - 2,683	2,684 +
2	\$0 - \$1,452	1,453 - 2,178	2,179 - 2,904	2,905 - 3,630	3,631 +
3	\$0 - \$1,830	1,831 - 2,745	2,746 - 3,660	3,661 - 4,575	4,576 +
4	\$0 - \$2,208	2,209 - 3,312	3,313 - 4,416	4,417 - 5,520	5,521 +
5	\$0 - \$2,587	2,588 - 3,881	3,882 - 5,174	5,175 - 6,468	6,469 +
6	\$0 - \$2,965	2,966 - 4,448	4,449 - 5,930	5,931 - 7,413	7,414 +
7	\$0 - \$3,343	3,344 - 5,015	5,016 - 6,686	6,687 - 8,358	8,359 +
8	\$0 - \$3,722	3,723 - 5,583	5,584 - 7,444	7,445 - 9,305	9,306 +
9	\$0 \$4,100	4,101 6,150	6,151 8,200	8,201 10,250	10,251
10	\$0 \$4,478	4,479 6,717	6,718 8,956	8,957 11,195	11,196
11	\$0 \$4,856	4,857 7,284	7,285 9,712	9,713 12,140	12,141

Full Fees Effective 2/1/20	Tier	Tier	Tier	Tier	Full Fee	DUI Fee
	A	B	C	D	Guar 1	Guar 2
90792 Psychiatric assessment (MD)	100.00	125.00	250.00	370.00	831.00	
90792 Psychiatric assessment (NP)	100.00	125.00	250.00	326.00	563.00	
99212 MD office visit 10 min	70.00	80.00	80.00	80.00	80.00	
99212 NP office visit 10 min	54.00	54.00	54.00	54.00	54.00	
99213 MD office visit 15 min	70.00	90.00	123.00	123.00	123.00	
99213 NP office visit 15 min	70.00	83.00	83.00	83.00	83.00	
99214 MD office visit 25 min	70.00	90.00	175.00	203.00	203.00	
99214 NP office visit 25 min	70.00	90.00	138.00	138.00	138.00	
99215 MD office visit 40 min	70.00	90.00	175.00	265.00	277.00	
99215 NP office visit 40 min	70.00	90.00	175.00	188.00	188.00	
H0001 CD assessment	40.00	50.00	95.00	140.00	198.00	130.00
H0031/90791 MH assessment	40.00	50.00	95.00	140.00	330.00	
H0048 Alcohol and/or drug testing; collection	23.00	23.00	23.00	23.00	27.00	20.00
H0004 indiv MH counseling (per 15 min*)	30.00	55.00	80.00	110.00	36.00*	
H0004BMI behavior hlth counseling, BMI (per 15 min*)	30.00	55.00	80.00	110.00	42.00*	
H0004CD indiv CD counseling (per 15 min*)	30.00	55.00	80.00	110.00	33.00*	16.25*
H0004CDBMI behavior hlth counseling CD, BMI (per 15 min*)	30.00	55.00	80.00	110.00	42.00*	
90832 indiv psychotherapy (16-37)	30.00	55.00	80.00	82.00	91.00	
90834 indiv psychotherapy (38-52)	30.00	55.00	80.00	110.00	127.00	
90837 indiv psychotherapy (53+)	30.00	55.00	80.00	110.00	220.00	
90846/90847 Family Therapy	30.00	55.00	80.00	110.00	147.00	
T1006 CD Family Therapy	30.00	55.00	80.00	110.00	132.00	
90853 MH Group Counseling (20-60 min)	15.00	20.00	35.00	41.00	49.00	
90853 MH Group Counseling (61-90 min)	15.00	20.00	35.00	50.00	74.00	
90853 MH Group Counseling (91-120 min)	15.00	20.00	35.00	50.00	98.00	
90853 MH Group Counseling (121-150 min)	15.00	20.00	35.00	50.00	123.00	
90853 MH Group Counseling (151+min)	15.00	20.00	35.00	50.00	147.00	
H0005 CD group 1 hr (20-75min)	15.00	20.00	35.00	50.00	55.00	40.00
H0005 CD group 1.5 hr (76-105min)	15.00	20.00	35.00	50.00	77.00	40.00
H0005 CD group 2 hr (106-150min)	15.00	20.00	35.00	50.00	110.00	40.00
H0005 CD group 3 hr (151+min)	15.00	20.00	35.00	50.00	132.00	40.00

Gray highlight indicates full fee is listed because it is less than SFS for that specific code.

* per 15 minute applies to full fee and DUI columns only. SFS fees are all per occurrence