Orange County Department of Mental Health Financial Intake

(Check all that Apply)

Client Name: ____________________ **Date of Birth:** ____________

☐ Fee-Insurance Information

☐ Copy of Insurance Card ☐ Health Insurance Claim Form CMS 1500 ☐ Financial Statements

If you do not have Insurance coverage and do not qualify for Medicaid coverage, your fee is set with consideration of your personal financial situation (This is known as a Sliding-Scale). This fee, or the Insurance co-pay, is to be paid each time that you come into the clinic for services. Payment is to be made regardless of whether you have insurance or not. Orange County policy states that if three consecutive payments are missed, your therapy can be temporarily suspended until your past due balance is paid in full or arrangements for installment payments are worked out with the Fee Negotiator. If you have insurance, you are responsible for providing us with signed insurance claim forms and/or a referral.

We will bill your insurance carrier according to our fee schedule for the services that have been provided. If you receive the insurance payment from your insurance carrier, it is your responsibility to turn this money over to the clinic. If the insurance payment plus your fees come to more than the full charge amount, we will refund you up to the amount you paid. If the insurance company denies payment, you will have no further obligation other than your fee. However, you will need to provide proof of denial documentation from your insurance carrier.

The clinic will not release any information to outside agencies (DMV, DRP, Probation, etc.) unless all fees are paid and insurance papers have been supplied.

☐ Medicare Authorization Assignment
☐ Medicaid Authorization Assignment

Health Insurance ID # ____________

☐ Copy of Insurance Card

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Orange County Department of Mental Health for any services furnished to me. Medicaid recipients must bring their Medicaid card to each visit to qualify for Medicaid coverage. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for the related services.

☐ Pending Medicaid Application Letter

☐ Three Visit Rule ☐ DSS Letter

I have asked for services from the Orange County Department of Mental Health. I am in the process of applying for Medicaid but at this time my Medicaid coverage is not in effect. I understand that the clinic will allow me three (3) visits while waiting for the Medicaid determination. I also agree that if Medicaid does not cover the services provided, I am responsible for these charges. This fee is established on a sliding scale.

____________________ ____________

Client/Legal Guardian Signature Date: