PATIENT INFORMATION SHEET

Court Ordered? YES NO_____Program:_____

PATIENT

Last Name:_____First Name:_____ Middle: _____

Gender: M F Date of Birth:_____ Age:_____ SS#_____

Mailing Address:_____ City/State_____Zip:_____

Home Phone #_____Cell Phone #_____

Is the Client Court Ordered? _____

INSURANCE

Primary:

Insurance Company: _____Phone #: _____
Insured's Name: _____ Insured's D.O.B.: _____
ID/Policy #: _____ Group#: _____

Secondary:

Insurance Company: _____ Phone #: _____
Insured's Name: _____
ID/Policy #: _____ Group#: _____

- We will need a front/back copy of your insurance card(s) for our records.

RESPONSIBLE PARTY

Responsible Party: _____ Relation to Patient: _____
Home/Cell Phone #: _____ Work Phone #_____
Employer Name: _____ Occupation:_____
SS#: _____Monthly Household Income: _____
Home Address: _____ City/ State:_____ Zip: _____
Mailing Address: _____ City/ State:_____ Zip: _____

- Complete this section if you are not the patient but are responsible for the bill.

SIGNATURE: (Patient, Parent, Legal Guardian, or Responsible Party)

I Request Services: _____ Date: _____

PAYMENT METHOD: CASH CREDIT CARD CHECK

CREDIT CARD INFORMATION:

Name on Card: _____ Card Number:_____
Expiration Date: _____ CVC Code: _____ Amount: _____

Updated 11/06/2020

EXPLANATION OF SERVICES FOR DAY TREATMENT & PAYMENT AGREEMENT

Youth Emergency Services provides family and youth intervention and family and children empowerment programs (Day Treatment) services to children from the ages of 8 to 17. Who are transitioning from out of the home placement or detention back into the community, who have been or would be expelled from public school and those at risk of out of home placement through court involvement and are in need of treatment. It is the goal of the Day Treatment Program to provide youth with education and treatment services while keeping them in their homes. Youth will receive group counseling, learn independent living skills, work with professionals to treat their substance abuse or mental health challenges, do school related homework and attend life skills sessions.

Individual and family therapy are a part of the program and include one individual session and one family session at least once every other week, a monthly treatment plan to ensure the family and child are working toward the same goals and a parenting class. Group therapy runs every day the program is in session. These will be billed to your insurance. Parent can request that their child be seen more often than once every other week if desired.

Day Treatment case management services are billed separately from therapy services. Therapy will be billed to private insurance, Medicaid, or the Children's Mental Health Waiver. A monthly rate of $350.00 will be billed, which includes the parents' portion of services and any co-pays. The services provided by Day Treatment staff include: Independent living skills, school related homework sessions and life skills sessions. These skill sessions include Character Counts, Corrective Thinking, Anger Management, and Team Building. The average length of the Day Treatment Program is 6 months. The first 6 months will be billed upfront for a total of $2,100.00. The first month's fee is due upfront; you will be sent a monthly bill thereafter with payments being due by the 10th of each month. The remaining amount can be broken into a payment plan of 6, 12, or 18 months. If the client leaves prior to 6 months, it will be the parent's responsibility to meet with accounting for proper credit for any months not used. If treatment services go beyond 6 months, parents will be billed $350.00 for each month exceeding 6 months.

We are dedicated to the treatment of your client and family. Please meet with our billing department should these finances stand in your way.

Total due for 6 months of service= $2,100.00

Down Payment: _____ Remaining Balance: _____
Payment Extended for _____ Monthly Payment:_____

Signature: _____ Date:_____
Witness: _____

There will be a $25.00 service charge on all returned checks.

The Y.E.S. House will make every effort to work with you to develop a mutually agreed-upon payment plan. We ask that you actively communicate with us and meet your payment agreements. It is our goal to avoid moving to a formal collection process. If collection becomes necessary by suit or otherwise, I, the undersigned, agree to pay all costs of collection, including all attorney's fees, court costs, filing fees. This includes charges or commissions that may be assessed to us by any collection agency retained to pursue this matter, which maybe as much as 50% of the principal balance owed.

I, the undersigned, have read the payment policies and do hereby agree to the terms of this payment agreement.

Dated this _____ Day of _____,20____

Signature_____

Witness_____

DAY & JR DAY TREATMENT

SLIDING FEE SCALE

Youth Emergency Services offers a sliding fee scale for Day Treatment & Jr. Day Treatment services. To qualify for a reduction in the monthly rate, you will need to provide your previous year's tax return along with 2-months' worth of wage stubs. Please see below for the sliding fee scale rates.

Monthly Wages	Payment
$5,001 – Plus	$350.00 per month
$4,001 - $5,000	$250.00 per month
$ 3,001- $4,000	$200.00 per month
$2001 - $3,000	$150.00 per month
$1001- $1000	$50.00 per month

Youth Emergency Services will not turn clients away for an inability to pay; the Yes House is committed to working with parents to establish a reasonable payment plan