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Financial Responsibility

Client Name: _____

Responsible Party (Individual responsible for all financial liability incurred for services): _____

Responsible Party Phone Number: _____ Billing Address: _____

- 1. The standard rate for clinical counseling services at Renewal is \$155 for initial assessment and \$125 per forty-five minute session...
2. The Responsible Party listed above is liable for payment of services on the day of your session...
3. If you have requested that your medical insurance be billed for mental health services at Renewal...
4. A \$25 fee will be charged for each bounced check.
5. The Responsible Party will be required to pay \$45 for any appointments that are cancelled less than 24 hours prior to the scheduled session time...

Method of Payment for Services:

- Insurance + Co-Pays/Deductibles/Co-Insurance
Sliding Fee Scale based on income level
Specify level:
Standard Rate SF1 SF2 SF3
Proof of Income has been provided.
Proof of Income has not been provided. Explain: _____

A member of the Renewal staff has discussed with me the cost of services. I agree that I am responsible for all of the charges for services provided to me or my dependent.

If I am utilizing my insurance benefits to pay for services at Renewal Center, I agree to do what is necessary for me to arrange for timely payment by those companies, and acknowledge that I am responsible for any cost of service that the insurance company does not pay.

If I am utilizing Renewal Christian Counseling Center's established Sliding Fee Scale, I certify that my household income is below the level indicated above and agree to pay the fee as outlined in the fee schedule.

I agree to pay my balance at time of service or in a timely manner thereafter.

Client Signature _____ Date _____

Parent/Guardian Signature (if applicable) _____ Date _____

Responsible Party Signature (if different from Client or Parent/Guardian) _____ Date _____

Witness Signature _____ Date _____