



Compass Behavioral Health Clinic

1820 Center Avenue · Janesville, Wisconsin 53546

Phone: 608 755-1475 Fax: 608 755-1733

Fee Information, Payments, Cancellation Policy, and Managed Care Tips:

Welcome to Compass Behavioral Health Clinic. We understand that searching for good counseling, including finding counseling agencies that are either affordable or that accept your insurance policy, can be a significant source of stress. Therefore, we work hard to keep our cost of services manageable, and, depending on circumstances, may be able to make arrangements to reduce the cost of services, so you can get the care you need.

Psychiatrist and Nurse Practitioner

\$300: Initial Psychiatric Evaluation

- Medication follow-up prices vary based on duration of appointment

Mental Health Counselor

\$190: Initial Evaluation

\$150 - \$170: Individual Session

\$ 90: Group Session

Psychologist:

\$210: Initial Appointment

\$175 - \$190: Follow-up Appts.

\$750 for full Psychological Testing

Addictions Counselor

\$190: Drug and Alcohol Assessment

\$150 – \$170: Individual Session

\$90: Group Session

\$45: Drug Screening (Breath and Urine)

Although many of our services may be covered by insurance companies, it is ultimately the responsibility of each consumer to ensure timely payment for services rendered. If you have a private insurance policy, please contact your appropriate representative(s) to determine if your policy will cover services offered at Compass Behavioral Health Clinic, as well as what your co-pays and deductibles will be. Co-payments will be due at time of service. If you do not have insurance, the full cost of the service rendered will be due before the service is offered.

Please call 24 hours in advance when you need to cancel or reschedule an appointment. Compass Behavioral Health Clinic allows one “no show” every six months because we understand that emergencies occur and life is often very busy. However, consumers will be charged 50% of the cost of service if more than one cancellation occurs in a 6 month timeframe. Continuous and excessive cancellations and “no show” may result in termination/discharge from Compass Behavioral Health Clinic.

Please note that insurance companies often need sensitive clinical information (in this case, psychiatric assessment results, diagnoses, and treatment plans) in order to cover services rendered. Our staff is obligated to protect the confidentiality of our consumers and will only give insurance companies information that is absolutely needed (with our consumers’ consents), so the services you participate in are covered adequately.



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Fee Information, Payments, Cancellation Policy, and Managed Care Tips Continued:

1. My signature below signifies I have read and agree with Compass Behavioral Health Clinic's fee and payment process (including acknowledging that the ultimate responsibility for payment is the consumer's or responsible party's), and that I understand and will comply with the cancellation policy:

Consumer or Responsible Party

Date

2. I hereby assign medical and psychotherapy benefits to which I am entitled (including Medicare, private insurance and/or other health plan benefits) to Compass Behavioral Health Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original copy. I hereby authorized said assignee (CBHC) to release all information necessary to secure payment on my behalf:

Consumer or Responsible Party

Date

3. By signing below, I accept responsibility for all charges not covered by my insurance company. This includes but is not limited to non-covered services, a covered service for which a prior authorization was denied or services that are not covered under my benefit plan or if my insurance changes and I neglect to inform Compass Behavioral Health Clinic. I also am aware that if my insurance does not cover Compass Behavioral Health Clinic, I am responsible for all charges incurred. The charges for such services are payable at the time of service. This agreement is valid for my entire course of treatment:

Consumer or Responsible Party

Date

Clients Name: _____