

COASTAL BEHAVIORAL HEALTHCARE, INC.

**CLIENT FEE RESPONSIBILITY**

In accordance with state regulations, Coastal Behavioral Healthcare is assuring that clients participate in the cost of their services. We want to help as many members of our community as we can, and while we realize that many people are facing financial challenges, everyone must contribute toward the cost of their care. This cost is based on either the type of insurance coverage you have or on **household income** if you have no insurance coverage.

You will need to provide proof of insurance coverage **or** proof of household income. We will then verify your co-pay amount or determine if you are eligible for a discounted fee, using our sliding fee scale, at that time and annually thereafter.

You will be asked for your co-pay or full fee **at check-in on the date of service**. Coastal accepts cash, checks, Visa or Master Card. A payment plan is available, but must be pre-arranged and approved by administration.

Income includes the following:

- |   |                                      |
|---|--------------------------------------|
| 1. Gross income (before taxes) from wages             | 7. Worker’s Compensation             |
| 2. Net receipts from self-employment                  | 8. Veteran’s Payments                |
| 3. Receipts from a person’s own incorporated business | 9. Public assistance                 |
| 4. Regular payments from Social Security              | 10. Training or educational stipends |
| 5. Retirement or pension                              | 11. Alimony                          |
| 6. Unemployment compensation                          | 12. Child support                    |

Proof of income may include tax returns (no older than 1 year), federal withholding tax (W-2), paycheck stubs, or bank statements. If you do not have any of these forms to prove your household income, you must go to the Social Security website, create an account, and obtain a **Social Security “wage and hour report”** for each adult member of your household.

**If you choose not to provide proof of income,  
or you choose not to use your insurance,  
you will be charged the full fee for the services you receive.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

ID# \_\_\_\_\_