If you do not have insurance that covers behavioral health services, you may be eligible for our generous sliding scale fee, or no cost services. Please work with our customer ambassadors to assist you.

In order to qualify you will need to provide proof of income & support, and our household size, and some other information required by our funders.

If you do not qualify for our sliding scale or no cost services, have significant co-pays required by your insurance, you may request to have a payment plan. Please ask for assistance. We want you and those you care about to receive the services you need.

PO. Box 10970 St. Petersburg, FL 33733
Administration: 727-327-7656 Services: 727-388-1220

Client Fee Agreement

Client Name:	Medical Record #:

Schedule of Services	Based on insurance or funding, your Fee/Co-pay at each visit/service if scheduled
Intake Services	
• **Assessment:** 60 minutes. Full Fee: **$150.00**	
• **Plan Development:** 30 minutes Full Fee: **$150.00**	
Individual/Family Therapy: 45-60 minutes Full Fee: **$150.00 per visit**	
Group Therapy: 60 minutes Full Fee: **$ 75.00 per visit**	
Psychiatric Evaluation: 45-60 minutes Full Fee: **$375.00**	
Medication Management: 15 minutes Full Fee: **$95.00 per visit**	
Independent Lab Tests	Check with your insurance company

___ Based on the Financial Investigation dated ____________I have reviewed the Schedule of Services and Co-pay Schedule above.

___ I understand that the services I am requesting are not free of charge. I understand that I am expected to pay for services if I do not have insurance that will cover the services.

___ I am uninsured/no third party payor and agree to provide the appropriate financial information upon request to apply for reduced fee based upon household size, household income.

___ I certify that the information I have presented verifying my household information is correct, and agree to inform Suncoast Center and renegotiate the reduced fee if there are changes in my income or insurability.

___ I agree to pay the cop-pay/for the provided services not covered by my insurance at the time of check-in.

___ I agree to pay the copay/reduced fee with the understanding that fees are based on the current information provided. Amounts are subject to change upon insurance/income verification.

______________________________ Therapy Services Primary Funder

______________________________ Medical Services Primary Funder

______________________________ Client /Legal Guardian Signature

______________________________ Date

______________________________ Staff Witness Signature

______________________________ Date

______________________________ Print Staff Name

______________________________ Date

Our reduced fee scale is based upon the current federal poverty guidelines, your household income, and the number of family members supported by the household income. We are able to provide some of these services to you at a reduced fee through funding received in part from:

The Department of Children and Families; Pinellas County Department of Health; the Juvenile Welfare Board.

SUNCOAST CENTER, INC.

CLIENT NAME and DATE of BIRTH (DOB) ____

(ALL CLIENTS) - VERIFICATION OF IDENTITY and FINANCIAL RESOURCES

Please provide us with one of the following items so we may determine the discount that you are eligible for.

ADULTS

1. Social Security Card *and*
2. Photo ID *and*
3. Proof of Insurance *or*
4. Proof of Income
   - Three current pay stubs *or*
   - Income Tax Return *or*
   - Unemployment verification *or*
   - Statement of Benefits (below)

CHILDREN

1. Social Security Card *and*
2. Guardian's Photo ID *and*
3. Birth Certificate/Custody Papers/Guardianship Papers
4. Proof of Insurance *or*
5. Proof of Income:
   - Current pay stubs *or*
   - Income Tax Return *or*
   - Unemployment Verification *or*
   - Statement of Benefits (below)

For Sliding Fee and Prescription Drug Assistance (IDP)

(SUPPORTERS OF UNINSURED CLIENTS WITH NO INCOME ONLY)

SUPPORTER INFORMATION

The individual/organization providing financial benefits listed below must complete this section and MAY BE REQUIRED TO ATTEND the enrollment in person.

****Picture ID of Supporter or Organization ID is required. ****

Individual/Organization Name (print): ____

Address: ____

Phone: ____

Individual's relationship to client: ____

I/We attest that the following financial benefits/support is accurate, truthful and being provided to the above client.

Describe type of support you provide below	Estimated Monthly Value
❑	

Supporter (print name) ____

Supporter Signature: ________________________________ **Date:** ________________

(ALL INSURED AND UNINSURED CLIENTS)

CLIENT INFORMATION

❑ Household Income (do not include Supporters Income)			❑ Number of persons in the household (do not include Supporters Household)	

By signing below, I certify that this information is accurate and truthful.

Client Signature: ____

Suncoast Center Employee (print name) ____

Employee Signature: ________________________________ Date: ________________

Signature verifying information above.