FAMILY STRATEGIES
COUNSELING CENTER

2018 GROUP PAYMENT INFORMATION
* * ALL GROUP PARTICIPANTS MUST COMPLETE * *

CLIENT NAME: ________________________________ **CURRENT GROUP:** ________________________

HOW WILL YOU BE PAYING YOUR GROUP FEES?
PLEASE CHECK ONE OF THE FOLLOWING:

______ **Self Pay.** Your card will be charged on the first of each month for the number of weeks group meets in the month. Credit card must be kept on file, or arrangements for paying otherwise approved by Family Strategies.

______ **Third-Party Payer**. If you have previously arranged for a third-party to pay for your fees, **please have them complete the "Third Party Payment Agreement" form and return it to the front office by your next group meeting.** It is your responsibility to be sure your account stays current. If your fees are 60-days past due, your card will be charged. Your card will not be charged until we have contacted you first.

______ **BCBS INSURANCE**

If your coverage is a deductible plan, it is very likely your deductible has started over as of January 1st. BCBS has determined each weekly group session allowable fee to be $60.08. This means, for example, if group is meeting four weeks in a month, and you have a deductible to meet, your card will be charged $240.32 on the first of the month until your deductible is met, and once met you will be charged your co-insurance amount only. This does not apply to copay plans. If you have a copay plan, you will be charged your copay for each week the group meets.

WE CANNOT BILL INSURANCE FOR A WEEK YOU DON'T ATTEND. SABR IS A MONTH-TO-MONTH COMMITMENT ANY WEEK YOU MISS YOUR CARD WILL BE CHARGED THE SELF PAY RATE OF $50.

BCBS ONLY. INFORMATION FOR THE PRIMARY INSURED– All Information is Required

Will your coverage change in 2018? Yes _____ No _____

NAME : ________________________ RELATIONSHIP TO CLIENT: ____________ DATE OF BIRTH: ____________
MM/DD/YY

INSURED ADDRESS: ____
Street City, State Zip

GENDER: M / F SSN: __ __ __ - __ __ - __ __ __ __ EMPLOYER: ______________________________

GROUP #: ________________________ INSURED SUBSCRIBER #: ______________________________

ALL GROUP PARTICIPANTS ARE ASKED TO KEEP A CREDIT CARD ON FILE.
DEBIT/CREDIT CARD AUTHORIZATION

Please circle the card type: ☐**VISA** ☐**MasterCard** ☐**Discover Card** ☐**Amex**

Name as it appears on the card: ____

Credit Card #: ____

Expiration Date: ____________ CVV# *on the back of the card*: __________ Zip Code: __________

SIGNATURE: ____ DATE:____________________

(signifies you have read and agree to these terms)

Your Phone Number: ________________ Your Email Address: ______________________________