



FEE AGREEMENT

P.O. Box 790 • Ashland, Kentucky 41105-0790 • 1-606-329-8588

Case Number:	Consumer Name:	
Section I: Eligibility		
1. Resident of Pathways' Catchment area? ☐ Yes ☐ No		
2. Total Family Annual Income: \$		
3. Has Income been Verified? ☐ Yes ☐ No: If yes, list verification source:		
4. Number of family members in household:		
5. Fee Scale based on above information:		
Section II: Fee Assessment		
I agree to pay Pathways the amount of fees that my third party guarantor reports I am responsible for paying. In the event I do not have a third party guarantor, or my third party guarantor does not cover the particular service or provider that I may receive, I agree to pay the fees listed in Pathways' Sliding Fee Scale. These fees are subject to change when either: (1) there is a change in my ability to pay such as employment status or third party coverage or, (2) on the annual anniversary date of my current Fee Agreement or, (3) when Pathways determines that current Fee Agreement conflicts with the agency's fee policy and/or fee scale. I also understand that payment is due at the time of service unless I have made arrangements with the office staff. Furthermore, I certify that all financial information provided is true, complete, and accurate, to the best of my knowledge. I understand that should it be determined that such information is not true; I will be responsible for paying Pathways' full fee for all services rendered from the date of this agreement. I understand that this agreement replaces any previous fee agreements. I have either received or have been offered a copy of the Fee Scale.		
Section III: Subscriber's Assignment of Benefits		
I hereby authorize my insurance company to pay directly to Pathways, Inc. for services rendered any and all sums of money otherwise payable to me under the terms and conditions of said insurance contracts. In the event that such payment is insufficient to meet the total charges for my account, I understand I am financially responsible and obligated to pay all charges not covered by this assignment.		
Section IV: Consumer's Release of Information for Insurance Billing Purposes		
I authorize Pathways, Inc. to release my medical records, including any alcohol or drug abuse data protected by Federal Regulation (42 CFR Part 2) or otherwise, together with any information relating to mental or emotional conditions, to any agency, insurance company, or other entity which might require them to process any claim on my behalf. I understand such information will NOT be released for any other purpose without my written consent. I understand I may revoke this authorization at any time in writing. If I do not, it will remain in effect for 24 months from the date I sign it.		
Section V: Authorization for Pathways to Assist in Appeals or Requests with Managed Care Organization		
In the event that I have Medicaid coverage through a Medicaid Managed Care Organization (MCO) and that MCO denies a service authorization or approves less than what has been requested, I authorize Pathways to file an appeal.		
Section VI: Validation of Fee Agreement		
I/We, the undersigned, hereby agree to the conditions described in the above sections.		
	/ /	
Printed Name of Consumer or Guardian	Date	Relationship if Not Consumer
	/ /	
Signature of Consumer or Guardian	Date	
	/ /	
Printed Name of Pathways Representative	Date	
	/ /	
Signature of Pathways Representative	Date	
Pathways Office Code		

