CORE Professional Services, PA Non-Grant Eligible / Telehealth Disclosure

Client Name: _____ DOB: _____ Monthly Fee: $220

Non-grant eligible rates are available to individuals who do not have insurance coverage, who wish to forgo use of their insurance and pay on the date of service in order to receive the discounted rates, or not eligible to utilize state grant funding. This fee disclosure covers the grant period that begins July 1, 2023. The rate of $220 per month for primary treatment and $110 per month for aftercare treatment will go into effect on August 1, 2023. You will be provided advance notice in the event of any fee increase. If you have questions about any of the information presented here or about your account, please contact the billing office. An intake or assessment must be paid in full prior to beginning treatment to determine if you are appropriate for treatment. Those services are not part of the non-grant eligible program. Payments made to CORE will be applied to past-due balance/oldest balance first.

The treatment program you are involved in requires you to participate as outlined in the treatment agreement. **Program fees will be billed for any month you are active in treatment.** ***ACTIVE IN TREATMENT*** refers to any month that you receive a group, individual, family, or couples counseling session, have a group assignment meeting, participate in a restorative justice meeting or community support meeting, or you are enrolled in the program **(even if no sessions are attended). The monthly fee is not based on how many times you are seen in a particular month but will remain the same for each month you are in treatment.** In addition to the monthly fee, there will be a fee for the polygraph examination. The polygraph fee must be paid prior to scheduling your exam and your account balance at $0.

Once you are accepted into the treatment program and are scheduled to begin, you are responsible for paying the monthly fee for each month of treatment. Payments are due by the 15th. If you have pre-paid, you will not receive a statement. Anyone who does not keep current on their account may be terminated from the program, as outlined in the treatment agreement. Cash, checks, money orders, and credit card payments (Visa, MasterCard, Discover, American Express) are accepted. Credit card payments may be made in person at any one of CORE's offices – Sartell, Brainerd, or Mankato, by utilizing the online patient portal or paying by phone by calling any one of those offices. By signing this form, you authorize payments to be made on your behalf. If fraudulent payments are made on your account, any fees associated with this will be assessed to you as the client. If a check is returned as "insufficient funds", you will be billed a returned check fee and will need to pay with cash or money orders. (***Do not send cash by mail***.) If at any point you wish to bill medical insurance or you become grant eligible (i.e.: on probation or supervision) and choose not to utilize insurance, you can opt into a grant program of $180 per month for primary treatment and $110 for aftercare treatment.

Signature:_____ Date: _____
(Client or Authorized Person and Relationship)

Do you have a Health Care Directive? _____ YES _____ NO
*If no, do you wish to receive information on this? _____ YES _____ NO

Primary Care Physician: _____ Practicing Location: _____
*If you wish for records to be sent to your primary care physician, please request to sign a release of information.

Mental health services are available by two-way interactive video or audio communications, referred to as "telemedicine" or "telehealth," which means that you may be evaluated and treated by a health care provider or specialist from a different location.

1. You will inform your provider if anyone is required to be present with you at your location, and you may give your verbal permission prior to the start of a session authorizing additional personnel to be present in the room with your provider, such as another provider, intern, etc. You may request that nonessential personnel leave the room(s) at any time to allow a private consultation with your provider
2. The therapist for whom the on-site examination or treatment is performed will keep a record of the encounter in your medical record.
3. If you participate in sessions through telehealth, you understand that you must be alone in a private location for this to occur. If there is any instance of breaking confidentiality of other participants, you may be immediately terminated.
4. You are not allowed to audio record or videotape any virtual group or individual session.
5. You must participate from a location within the state lines.

Noting all the above, you understand that your participation in telehealth services is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data. By signing this form, you acknowledge that the providers involved have explained the telehealth encounter in a satisfactory manner and that all questions that you may have about the telehealth encounter have been answered satisfactorily. Understanding the above, I consent to the telehealth process described above.

Signature:_____ Date: _____
(Client or Authorized Person and Relationship)