Coastal Mental Health Center
665 W. Warren Ave
Longwood, FL 32751

CMHC Insurance Statement

CMHC strives to work with all health plans available in all our counties of operation.

Your insurance is a contract between you and your insurance carrier. CMHC expects patients to do their part and be responsible with communication on any issues with your insurance carrier. It is your responsibility to provide CMHC with any changes or updates to your insurance coverage when they occur. Failure to provide information, including but not limited to your Social Security number to CMHC may result in the patient being responsible for payment of all charges. It is the patient's responsibility to know if CMHC is in network with your Health plan.

CMHC is not in network with Medicare and Medicare Advantage. Therefore CMHC is not accepting new patients. Current patients whose insurance switches to Medicare or a Medicare Advantage plan, will be discharged with a prescription for 30-day supply of medication and referred to your new insurance carrier to find you a provider in network.

Please read the following in regards to patients who have insurance CMHC is not in network with and would like to stay with CMHC as "Self pay" and pay out of pocket:

- Each visit will need to be paid in full. CMHC self-pay rates are as follows.
  Initial Assessment (conducted annually) $100
  Psychiatric Evaluations (conducted annually) $175
  Clinic visit (monthly) $50
  Therapy (bi-weekly) $50
- Pharmacy prescription coordination will not be handled by our staff. Your medications may not be covered by your insurance payer.
- Once a patient becomes self pay, the amount collected at appointment will not be applied towards the insurance plans deductible and/or out of pocket accumulations.
- Please be prepared to pay any balance at time of service unless a payment plan has been established by CMHC.
- If patient is a minor, the parent or legal guardian is responsible for payment.

If you have lost your insurance coverage or do not have insurance or wish to self-pay and would like to remain as a patient with CMHC under the above stated conditions, please type/print your name, sign and date on lines below and return it to our office within 14 days of receipt of this form. You may return this form to the receptionist at the office or mail it to the address written above. If you have not mailed it (post marked within the 14 days) nor returned it to the office, we will consider this as your decision to not continue treatment at CMHC and proceed with discharge.

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Print Name Signature Date

Patient/Parent or Legal Guardian