Record of Copayment

Client Name _____ Provider Name _____

Amount paid $ _____ for the service date of _____

If the amount paid covers more than one service date, list the dates of services being paid: _____

_____

___ Cash ___ Check ___ Credit Card ___ Money Order

Is client income at or below the Federal Poverty Level according to KyHealthNet? Yes _____ No _____

If a client does not pay the copay at the time of the session, ask the client to sign this statement:

Client Payment Statement

I am unable to pay my copayment for today's services.

_____ _____

Client or Guardian Signature Date of Service

Provider shall submit the top of this form to the office along with payment received
Cut and give bottom portion to client for the client's records.

Payment Receipt for Client

Date of Payment _____

Client Name _____

Amount _____

_____dollars

_____

Provider Signature

Transformationsllc.net

This Provider is independently contracted with Transformations to provide mental health services

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