FEE Agreement and FINANCIAL POLICY

Thank you for choosing Center for Sexual Health & Wellness, LLC. Please review this fee agreement and financial policy (the "Agreement and Policy"), which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, **please ask your provider prior to signing this Agreement and Policy.**

Our service rates and corresponding health insurance billing codes (numbers starting with '90' refer to mental health services)

- 90791 Initial Consultation – Individual (50-60min.) $200.00
- 90837 Individual Therapy (60 min.) $175.00
- 90834 Brief Individual Therapy (30 min.) $100.00
- 90847 Couples Therapy* (60 min.) $175.00

Charges Not Covered by Insurance

- Case Management* $100.00 - $120.00 (pro-rated per 15 min.)

***Case Management includes indirect services I provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of subpoena from the court the time billed will begin from our arrival at the courthouse to completion of testimony.**

- Phone Consultations (16 – 60 min) $130.00 (pro-rated per 15 min)

- Substance Abuse Evaluation with report $200.00
- Psychiatric Evaluation (Two Part) $250-300
- Medication Management Appointments $100

Additional Fees

- Late cancellation/Missed Appointment/Rescheduling – fewer than 24 hrs. prior to appointment is the full price of session ($60.00 - $150.00)
- Past due accounts $10/day late fee, over 14 days turned over to legal for collections.

Payment

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the **Outpatient Services Agreement**, which will be given to you along with this Agreement and Policy and our **Notice of Privacy Practices.** Accepted methods of payment are cash, debit or credit cards.

Insurance Reimbursement

Center for Sexual Health & Wellness, LLC accepts and process insurance payments through a variety of insurance providers and Employee assistance plans. If you are using insurance or Employee assistance provider to pay for our services, then we will:

- Expect and accept payment of your copayment amount at the time of service
- File your claim with the insurance provider
- Receive payment from your insurance provider
- **Expect that you pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.**

Please Note

Center for Sexual Health & Wellness, LLC files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If your insurance company denies a claim filed on your behalf, then you are responsible to pay Center for Sexual Health & Wellness, LLC for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owner of Center for Sexual Health & Wellness, LLC.

I agree (1) allow Center for Sexual Health & Wellness, LLC to bill my insurance directly for services provided under the Outpatient Services Agreement (2) give Center for Sexual Health & Wellness, LLC permission to release any information the insurance company may require in order to process payment; appoint Center for Sexual Health & Wellness, LLC as my authorized representative to act for me in obtaining payment (3) assign all of my rights to claims and payment by my insurance to Center for Sexual Health & Wellness, LLC and (4) agree to assist with the claims process as required by Center for Sexual Health & Wellness, LLC my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Patient name (print)_____

Patient/Guardian signature: _____

Private/Self-Payment for Services

I will self-pay for services at Center for Sexual Health & Wellness, LLC, I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Patient name (print)_____

Patient/Guardian signature: _____

Cancellations & Missed Appointments

Insurance carriers will not pay for late cancellations or missed appointments. This will be the client's responsibility. Once an appointment is scheduled, that time is reserved specifically for you. Cancellations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule please give as much notice as possible. You may notify our office of cancellation by phone or email to your provider. Late cancellation/ Rescheduling (fewer than 24 hours before the appointment) will incur a fee full session price $60.00 -$150.00 depending on contractor's rates.

Past Due Accounts

Amounts past due by more than same day will incur a late fee each day $10.00. If your account has not been paid for more than 14 days and arrangements for payment have not been agreed upon, the Center Sexual Health and Wellness will resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

Patient name (print)_____

Patient/Guardian signature_____

Credit Card on File

Upon scheduling your first appointment you have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, or past due account balances. A

receipt will be e-mailed to you at the address you specify below at your request or by email. **If you refuse to keep a card on file or do not wish to**, please note that you may be asked to pay for all sessions at the time of scheduling.

Type of card (Circle)
___Visa ___MasterCard ___ American Express ___Discover
Credit Card#___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___ -___ ___ ___ ___
Expiration Date_____
Security Code Number_____
Name on card:_____Initial here_____

I authorize Center for Sexual Health & Wellness, LLC to charge this credit card as needed according to the terms specified in this Agreement and Policy.
Signature_____ Date_____
I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Center for Sexual Health & Wellness, LLC. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by a representative of Center for Sexual Health & Wellness, LLC.
Patient name (print)_____
Patient/Guardian signature_____