THE BRIARWOOD CLINIC FINANCIAL AGREEMENT

Patient Name: _____

This is a private outpatient fee-for-service clinic. We will process insurance claims for you at no additional charge. It is expected that you pay your co-payment, deductible or other balance at the time of each visit. Please note that your insurance company will not guarantee benefits over the phone. If you have questions regarding your benefits from your insurance company it is recommended that you call and talk to your insurance representative. ****Services that do not fall under the category of "medically necessary" are not billable to insurance, and therefore a direct charge to you, the client or responsible party. These fees are due at the time they are incurred.**

Common Services (includes Teletherapy)	FEE	Common Services	FEE
Initial Diagnostic Evaluation, 30-60 min	$160.00	**Court Testimony w/ travel	$250.00 hr
Individual psychotherapy, 45-60 min	$130.00	**Report of psychological status/history	$125.00 hr
Individual psychotherapy, exceeding 60 min	$195.00	**Review of patient-provided materials	$30.00 @ 15 min
Individual psychotherapy, 30 min	$65.00	**Telephone Consult or Therapy (with therapist, beyond 10 minutes)	$30.00 @ 15 min
Family/Couple psychotherapy, 45-60 min	$140.00	** Reproduction of Medical Records *Additional fees may apply* ***~These fees do NOT pertain to non-medical records***	1-10 -$1 ea 11-50 -50¢ea 51+ -25¢ea
Psychological/ NeuroPsych Testing *Total fee will be determined after the Initial Evaluation. Testing may or may not be covered by insurance. We will attempt to make this determination prior to testing.*	$175.00 per hr/unit	** Same Day Late Cancellation **Missed Appointment - No Notice Given (No Show)	$35.00 $50.00
Patients without insurance are welcome to a reduced fee, due at the start of each session to avoid a monthly billing fee		**Returned Check Fee	*Bank imposed*
** Self Pay Initial Diagnostic (30-60 min)	$75.00	**Emergency After hours Page	$50.00 (+office visit, if applies)
** Self Pay Individual therapy (30-60 min) ** Self Pay Family/Couple therapy (30-60min)	$65.00 $75.00	**Monthly fee for services not paid in office (When statement is mailed)	$5.00

MISSED APPOINTMENTS - I understand the provider may exercise the right to terminate the patient/therapist relationship if sessions are not cancelled in a manner which is acceptable which does not create an inconvenience to the clinic or therapist's ability to maintain a workable schedule. I understand I am responsible for fees associated with same day cancellations or missed appointments.

PAYMENT GUARANTEE - I am the guarantor, or Responsible Party for payment of fees for the patient named above. I understand the fees for services. I authorize release of all information necessary to process insurance claims or to bill to responsible parties. I authorize payment for services provided to be paid directly to the Clinic. Should insurance payments be sent to me, I agree to immediately pay the clinic the amount paid by insurance. I fully understand services billed but not covered by insurance will be my responsibility and I agree to pay said fees. In consideration of the services to be provided to the patient I hereby guarantee payment in accordance with the financial agreement stated herein, and further guarantee to pay expected fees at the time of each session, or within 10 days of being notified of a balance due. I understand in the event of default in payment, reasonable collection and/or attorney fees shall be added to the amount due at the time it is placed for collection.

I agree to communicate with the billing manager any concerns I have regarding payment of outstanding balances in an effort to avoid additional fees due to non-payment. **I understand it is MY responsibility to inquire about any balance I may owe on ALL accounts, and to provide current and accurate insurance information and billing addresses at all times. Unpaid balances will result in termination of services at this office.**

AUTOMATIC BILLING OF CREDIT CARD – For your convenience, you may opt to keep a credit card, Health Savings Account or Flex Spending Card on file to be processed automatically for each session/or incurred fee. This would include deductibles, co-pays, self-pay fees or unpaid balances including late cancellation or no show fees. Cards on file are typically processed once per week, but may not always be processed on the same day as your session. You may request monthly statements reflecting charges posted to your account.

If you would like to take advantage of this option, please complete the information below, then contact the office right away to provide payment info.

[ ] Visa [ ]Mastercard [ ]Discover [ ]American Express HSA/HRA? [ ]Yes [ ]No

Card Holder Printed Name: _____

Card Holder Signature:_____ Date: _____

Yes, I agree to keep an active credit card on file and give my consent to automatically process any fee or outstanding balance including missed appointment fees (No Show - $50 Late Cancellation $35) associated with the above-named patient account as reported by insurance (if applicable). If my credit card is declined or becomes inactive, I understand I will be billed immediately and may be subject to additional fees related to processing.