Bridge to Wellness Centers LLC

Financial Agreement

Thank you for choosing ***Bridge to Wellness Centers LLC****.*
Below is information regarding patient financial responsibility.

****Please note: Client and financially responsible party must sign this form****.*

Payment Options

I agree to pay for services ***(please initial):***

_____ (Initials) ● cash rate of _____ **per therapy session and/ or** _____ **for psychological testing, and/or** _____ **per hour of neurofeedback.**

I authorize Bridge to Wellness Centers LLC to charge the credit card on file at the above agreed upon rate(s).

Payment, Insurance Reimbursement and Receipts.

Some insurance companies reimburse for our services. It is important for you to know that we are not participating providers for any insurance company. We will provide an insurance-ready receipt that can be submitted to your insurance company for out-of-network reimbursement. It is your responsibility to verify the specifics of your coverage and to submit your claims to your insurance provider.

Bridge to Wellness Centers LLC

If you have insurance through Medicare or TRICARE, please inform us at the initial visit. Reimbursement through these insurance programs may not be available. If you do not want any communication from Bridge to Wellness Centers with your insurance company, please inform us in writing or simply do not submit your claims to them. Claims not submitted keep your records the most confidential.

Receipts for services at Bridge to Wellness will be available to you by email on the next business day.

Place a check mark here _____ if you do not want receipts emailed to the personal email address you listed on the client Information form. We can make other arrangements with you.

Payment is due in full for each session at the time of your appointment. Payment may be made by cash, or credit card/debit card, No checks.

Fees for Professional Services

- **$150** per 50 minute therapy session
- **$150** per 50 minute couples therapy session
- **$200.00** per unit, minimum of 3 units, for psychological evaluation
- **$75** per 20-30 minutes for lengthy phone calls, or standard rate for letters, reports, addendums
- **$250** per hour if requested to respond to a subpoena. Any and all court work is also $250 per hour, including preparation, travel, and time in court not covered by insurance. In anticipation of a court appearance by the undersigned provider**, a deposit of $1,000 must be made prior to the court date.** Unused funds will be refunded in a timely manner.

Late/No-Show/Cancellation Policy

1. Please provide our office with at least 24-hour notice to change or cancel an appointment.
Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change an appointment may be responsible for:

- **$75.00** office visit charge for an hour therapy session
- **$200.00** office visit charge for a testing session_____ (Initials)

2. Please also be advised that showing up late, no more than two non-emergent cancellations, or missing multiple appointments may result in being dismissed from the practice. This allows Bridge to Wellness to fulfill other clients' scheduling needs and keeps the practice operating efficiently. _____ (Initials)

Bridge to Wellness Centers LLC

Credit Card on File

All clients are asked to keep a credit card on-file to be billed for agreed upon fees and no-show fees. Upon arrival (or prior to your session), your credit card will be charged for the session fees. Please note that if your credit card is declined, you will have the option of using a different form of payment (i.e. cash or another credit/debit card) at the time of service. Services will not be provided without approved payment. If your card on-file is used for the agreed upon fees above, receipts are automatically sent to the email address on file. In case of No-Show fees, you will be notified by email of charges to credit card.

Information to be completed by the Card Holder:

Cardholder Name (as shown on card):

_____

Card Number:

_____

Card Type (e.g. Visa, Mastercard): _____

CVV: _____ Exp. Date: _____/_____Billing Zip Code: _____

Email Address for Receipts:

_____

Contact Information of Financially Responsible Party:

Name: _____

Address: _____

City: _____ Zip: _____ Phone: _____

I, _____, authorize Bridge to Wellness

Centers, LLC to charge the credit card on file for any agreed upon fees, no shows for therapy or assessment services, unless an alternative payment arrangement is made. I understand that my information will be saved to file for these transactions on my account. This authorization will remain in effect while I am a client at Bridge to Wellness Centers.

Bridge to Wellness Centers LLC

By signing, I also verify that my credit card information provided above is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and 5% surcharge per month for unpaid balances.

I also understand by signing this form that if no payment has been made, my balance is subject to collections if another alternative payment is not made within 30 days.

I have read and understand the Financial Agreement and accept responsibility of the above terms.

_____

Client Signature Printed Name Date

_____

Financially Responsible Party Signature Printed Name Relation to Client Date

_____

Clinician Signature Printed Name Date