Bridge to Wellness Centers LLC

Financial/Service Agreement

Thank you for choosing ***Bridge to Wellness Centers LLC****.*
Below is information regarding client 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 $200.00 for evaluation/intake, $150.00 per hour of therapy session and/or $200.00 per hour for psychological testing, and/or $175.00 per hour of neurofeedback.

Payment, Insurance Reimbursement and Receipts.
At the beginning of services, you can make a choice to pay for services out-of-pocket or to file through your insurance. If you choose to file claims through your health insurance company, our agency will submit insurance claims, on your behalf, for those insurance carriers in which our agency is an in-network provider and for those services which have been determined to be covered under your insurance policy. It is important for you to know that our agency will not submit claims for non-covered services and those fees are due at time of the service.

If our agency does not participate with your insurance carrier, we will provide an insurance-ready documentation that can be submitted to your insurance company for out-of-network reimbursement. It is your responsibility to verify the specifics of your coverage prior to receiving clinical services.

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Insurance deductibles and co-payments are due at the time of the service. The deductible amount will be collected by this agency until fulfillment of this obligation is verified by this agency. This agency cannot guarantee any benefits or amounts covered; nor are we responsible for the collection of such payments. There are instances when insurance companies or other third-party payers may deem certain services not reasonable or necessary or may determine that services are not covered. Clients remain responsible for all payments for services provided regardless of any insurance carrier's arbitrary determination of usual and customary rates.

The responsible billing party is financial responsible for any account balances not paid by insurance carriers or third-party payers after 60 days. Payments not received after 60 days are subject to collections. A 5% per month interest rate is charged for balances 60 days or older. All insurance benefits will be assigned to this agency (by insurance carrier or third-party provider) unless otherwise specified in our contract with your insurance carrier.

Clients with accounts exceeding $100.00 outstanding balance will be unable to schedule new appointments until the account is paid in full or payment arrangements are made. Clients are responsible for payment in full at the time of services, including insurance co-payments, deductibles, or full fees for self-pay services.
In cases when the client is a minor, the accompanying adult is responsible for payment at the time of the service. Unaccompanied minors will be denied **nonemergency services** unless payment has been preauthorized to an approved credit plan, charge card, or payment is made at the time of service.

HMO CLIENTS:
_____(Initials) Please note that if you are a subscriber to an HMO Plan through your insurance carrier, you MUST obtain a PCP referral prior to your initial visit. It is YOUR responsibility to verify the specifics of your coverage prior to receiving clinical services.

MEDICAID/MEDICARE CLIENTS:
_____(Initials) Please note that Bridge To Wellness Centers LLC is not a participating provider for Medicaid or Medicare. If you have insurance through Medicaid or Medicare please inform us at the initial request for an appointment. Failure to notify Bridge To Wellness Centers LLC will result Reimbursement through these insurance programs may not be available.

TRICARE WAIVER:
_____ (Initials) Please note that Bridge To Wellness Centers, LLC is an Out Of Network provider for TRICARE. By initialing this section of the financial/Service agreement, I acknowledge and accept responsibility to pay in full for the clinical services at the time of treatment. I acknowledge that TRICARE's reimbursement rates for Out OF Network services are generally less than rates charged by Bridge To Wellness

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Centers LLC. As a service to you, Bridge To Wellness Centers LLC will file the claim to TRICARE and client will be reimbursed directly by TRICARE.

Fees for Professional Services

- **$200 for evaluation/intake**
- **$150 per 50-minute therapy session**
- **$150 per 50-minute couples therapy session**
- **$200 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.**

Returned Check Policy

The return of a check issued to Bridge to Wellness Centers LLC will result in a **$50.00** returned check fee being placed on the account of the client whose behalf the check was presented for each returned check, no matter the reason. Written notification communication on how to resolve the returned check will be sent to the maker of the check, and to the person who account was affected. A hold will be placed on the account affected and no further services will be provided until the returned check has been redeemed. If the returned check has not been redeemed within the stated time frame on the notification, a late fee not in excess of 10% of the past-due amount will be levied, and the agency will begin its collection proceedings.

Late/No-Show/Cancellation Policy

1. Please provide our office with at least 24-hour notice to change or cancel an appointment. Clients who do not attend a scheduled appointment or do not provide 24hour 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)

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 copays, co-insurance, self-pay/direct rate, 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 until termination of services at Bridge to Wellness Centers.

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 60 days.

Bridge to Wellness Centers LLC

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

Financial Agreement 2/26/2021