Financial Agreement and Promise to Pay Account

For in and in consideration of services rendered and to be rendered to _____,
I will promise to pay City to City Psychiatric Services, Inc., dba, WellMed – "hereinafter WellMed. I understand that the total charges are due when services are rendered.

I agree to pay for services and documentation requests not covered by my insurance

.____ (initial)

I agree to make available any and all personal insurance information to WellMed and/or its billing office team. I understand that WellMed has the following rate schedule if you either do not possess insurance or your insurance does not cover a procedure. Those rates are as follows:

- Psychiatric Evaluation - $350 per session
- Med Management - $100 to $150 per session
- Individual Therapy - $90 to $150 per session
- Prescription Pickup Fee - $25
- The following are charged a rate of $87.50 per 15 minutes of time to complete:
    - Telephone Consultation
    - Form Request that require an expert opinion, includes but is not limited to:
        - Disability Forms
        - Workmen's Comp
        - Adoption Forms
        - Social Security claims
        - 504 plans
        - Letters of any type
        - Questionnaires given by an Attorney or Agency
    - **All Form Request for Disability, Workmen's Comp, and Work Leave, will only be considered after the 2nd MD visit and after all form fee have been paid**.____(initial)
    - **Once again: All Form Fees MUST be paid at the time of the request and may take up to 30 days to complete.**____ (initial)

I agree to provide insurance claim forms of any insurance company. I agree to pay the entire deductible amount, as well as any co-payment amount due at the time of service._____(initial) I also agree to pay before any follow up appointment, any outstanding debts that our owed for service rendered by WellMed._____(initial)

You are financially responsible for any fees we apply for legal/court related matter.___ (initial)

For in and in consideration of court attendance, I will promise to pay WellMed $500 per hour for court attendance. I understand a fee of $2000 will be paid at least 14 days prior to court attendance, and is nonrefundable is less time is needed. If the court attendance exceeds four hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for our expert testimony; rather, I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not._____(initial)

FOR OFFICE USE ONLY:

Fees provided to WellMed will be assigned to the following:

- Keisha M. Brown, MD
- Jenelle Martin, MD/PC

I understand that I must pay "up front"-- $75 per 15 minutes of time to complete -- for any time a WellMed therapist or Psychiatrist has to spend dealing with legal issues (responding to subpoenas/court orders, phone conversations, letter writing etc.). I understand that the WellMed provider will review my request and determine the appropriate fee that **MUST** be paid before any work is completed. I understand I hold **Complete Financial Responsibility** for any legal fees that WellMed incurs due to myself or my Minor child (even if I am not the one making the request). I understand that all fees will be paid prior to my therapist/psychiatrist responding to any legal issue and that I am paying for WellMed's Time and not the Response.____(initial)

You agree to pay fees associated with missed appointments._____(initial)
I understand that I am financially responsible for missed appointments, in which I do not give a 24 hour notice and that I will be charged $90 if I do not give 24hrs notice. This fee **MUST** be paid before you can make another appointment. I also understand that if I cancel twice without giving 24 hours' notice, that WellMed has the right to terminate our Psychiatrist/Therapist-Patient relationship. The following will occur upon termination:

- A letter of termination will be sent to your home
- Your Psychiatric evaluation and last follow up note will be available upon request
- One prescription refill will be given provided you have been seen in the last 60 days

Please note you will cease to be a client if your cancellations have led to an absence of over four months from our office. (____) initial

I agree to pay WellMed if my insurance company untimely pays for your date of service.
___ (initial)
I understand that if my insurance company fails to pay for each date of service within six weeks, you will be billed for the date of service. You will be provided with the super bill so you can be reimbursed by your insurance company. In this process, if payment is received after the 4th weeks' period, then you will be reimbursed by this office. BY signing this Agreement, I completely understand that it is my responsibility to handle all insurance matters, including getting authorization and untimely payment by my insurance company (more than 4 weeks after date of service). I understand that WellMed will file each date of service **ONE TIME** and any rejection of payment from my insurance company will be taken care of by me before my next appointment. _____. (initial)

I understand that I am financially responsible for all charges not covered by this authorization IF I received services, yet, did not initial and/or sign this Agreement. ___ (initial)

You also agree to provide WellMed with your current credit card information when submitting this document. This data will be secured in your file and will be charged when you confirm your appointment. I understand that if I should receive services, yet, refuse to initial and/or sign this entire Financial Agreement, that my credit card will be charged for any coinsurances, copayments, late fees or balances owed. . ___ (initial)

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I understand that I am financially responsible for all charges not covered by this authorization. ___ (initial)
I understand that if I should receive a payment from the insurance company by mistake, which payment was assigned to WellMed, I will sign this payment over to WellMed. Finally, if I do not pay the entire amount due to WellMed, I hereby agree and give permission to WellMed to seek legal action to receive payment for services rendered and/or work with WellMed's collection agency to resolve payment. I understand that I am responsible for paying the collection and/or legal fees should my account be turned over to collections. I also agree that in the event it is necessary to retain an attorney to enforce the terms of this Agreement, relative to the payment of fees, WellMed shall be entitled to all reasonable attorney fees and collection costs.____(initial)

By Signing below, **I AGREE** to ALL terms and conditions of this financial Agreement.

Signed: _____ Date: _____

Witness:_____ Date: _____

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