Embrace Recovery & Wellness Center

FINANCIAL AGREEMENT

FULL NAME _____ TODAY'S DATE _____

FEE FOR SERVICES

I understand that unless another payment schedule is specifically arranged the following fee agreement applies:

$125 Initial Assessment/Consultation (90791) $100 Individual or Couples Therapy (90834 or 37)
$25-$50 Group Education or Therapy ** $25 Phone/Face to Face Consultation (15 minutes) **
$250 Mandated Assessments (include: Clinical Interview, letter & case management/collaboration) **

** indicates that these services are **NOT** billed to insurance.

MISC SERVICE FEES

These are any extra services not covered by your insurance.

- Letter or Report writing- $25 - $100, based on time and complexity. Payment is required prior to writing letter.
- Telephonic Services- $25 per 15 minute increments.
- Court Related Charges-Your therapist will not go to court voluntarily. Please understand that when your therapist goes to court other clients have to have their appointments canceled for the week. The Magistrate of Judge hearing your case must subpoena the therapist.
  - The office must receive a retainer cost of $500.00 prior to therapist blocking out their schedule to appear in court.
  - Any additional charges over that will be billed to you following the hearing.
  - In the event the therapist believes that testifying in court would be detrimental to the therapy process the therapist may hire their own attorney to have the subpoena overruled. Any legal fees resulting from this action will be charged to the client that has requested the therapist's appearance.
- Drug Testing- Prices for testing vary and are available upon request.
- Medical Record request: Actual cost of postage to send records

CANCELLATIONS & MISSED APPOINTMENTS

I understand that I am required to provide at least **24 hour notice** if I (or the client named below) am unable to keep a scheduled appointment. In the event that I do not provide **24 hour advance notice**, I acknowledge that ERWC has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come to set appointment at my (or the client's) scheduled appointment time, I understand that ERWC will charge me $50.00 for the scheduled appointment. I agree to pay ERWC **$50.oo late cancellation or missed appointment** charges incurred.

HEALTH INSURANCE

Insurance: **(Please check the appropriate box)**

□ I do have insurance that provides coverage for mental health and/or alcohol/drug treatment services. I am requesting that ERWC bill my insurance provider. I agree to pay all deductibles, and/or co-insurance associated to the services I receive at ERWC.

□ I do not have insurance that provides coverage for mental health and/or alcohol/drug treatment services.

□ I request that whether or not I (or the client named below) have insurance that may provide coverage for mental health and/or alcohol/drug treatment services. ERWC not bill my insurance company for privacy reasons. I acknowledge that with my request that ERWC not bill my insurer creates a personal financial obligation on my part.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the therapist. ☐

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL# _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICES PHONE (Located on back side of card) _____

Do you have any additional insurance? ☐ YES ☐ NO (If YES, please complete the following):

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____

NAME OF EMPLOYER_____ UNION OR LOCAL# _____

INSURANCE COMPANY _____ MEMBER ID# _____

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, be made on the client's behalf to ERWC for any services provided to the client. It is my responsibility to notify ERWC of any changes in my health care coverage.

Some, or all of your fees may be covered by your health insurance, if you have outpatient mental health coverage. However, insurance companies **DO NOT** reimburse all conditions that may be the focus of therapy. As a consideration to you, we will do initial verification of benefits however, it is your responsibility to verify the specifics of your coverage. Please remember that services are charged to you not your insurance company, so you are responsible for the payment. Fees you pay out of pocket for services that are not reimbursed by insurance may be deductible as a medical expense if you itemize deductions on your tax return.

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

I understand that if I am unable to honor my financial commitment that this may be grounds for a therapeutic conversation about financial issues, negotiating my therapeutic & financial agreement, exploring other options and or terminating from treatment.

I understand that ERWC may, in its discretion, charge a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay ERWC a returned check fee of up to $35.oo.

I understand that ERWC may turn my account over to a collection agency if I do not pay on a timely basis. ERWC has a separate collection policy, which will be provided to me if I ask for it. I also understand that if my account is sent to a collection agency a 35% surcharge will be applied to the balance by the collection agency.

I acknowledge that I am financially responsible for all charges associated with mental health services provided by ERWC to me (or the client named below). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

_____ _____

Signature of Responsible Party **Date**

_____ _____

Staff Signature **Date** 9/16