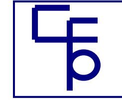
Effective June 1, 2014

Center for Family Psychiatry, PLC



Name: ______________________________ DOB:____________________

BILLING & FEE AGREEMENT

I UNDERSTAND THAT…

- ❑ Payment is expected at the time of service.
- ❑ I will be charged a $100.00 fee for cancellation less than 24 hours before the initial evaluation or a no show for the initial evaluation.
- ❑ I will be charged a $40 fee for cancellations with less than 24 hours notice and a $60 fee for a no show;
- ❑ the clinic reserves the right to turn unpaid balances over to an outside collection agency;
- ❑ **I will be charged a $5 late fee every 30 days when my balance owed exceeds $50 AND I have not made a payment in the past 30 days. Effective June 1, 2014.**

IF MY INSURANCE COMPANY COVERS MENTAL HEALTH SERVICES, I UNDERSTAND THAT…

- ❑ it is my responsibility to understand the insurance benefits, including limitations and/or exclusions, co-pays, and yearly maximum benefits, and whether the insurance carrier requires that I call for authorization of the first appointment (of which I am responsible for the session fee if this authorization is not obtained);
- ❑ each appointment counts as one visit and most insurance companies will not pay for two appointments in one day and (if applicable) I will schedule my appointments with my doctor and therapist on different days;
- ❑ I am responsible for any or all deductibles or co-pays required by my insurance company, as well as, any portion that is not covered by my insurance company;
- ❑ it is my responsibility to inform the clinic staff of any changes in my insurance coverage;
- ❑ Telehealth codes may be billed to my insurer, if my insurer does not cover these codes, they may be my responsibility
- ❑ Changing of diagnostic codes is fraudulent and illegal, **CFFP WILL NOT change a diagnosis code under any circumstances**

Patients insured by Medicaid or a Medicaid HMO, I understand that…

- ❑ my plan may have limitations on the number of mental health visits I am allowed yearly, it is my responsibility to keep track of these visits, which may include other providers outside of CFFP
- ❑ if I exceed the allowed number of visits, payment to CFFP becomes my responsibility
- ❑ if I become ineligible for the Medicaid HMO CFFP participates with, payment is my responsibility
- ❑ CFFP DOES NOT participate with straight Medicaid and will not bill them, if at any time my insurer becomes straight Medicaid, payment is my responsibility

SERVICE FEES:

Psychiatrist (M.D.)				Therapist (Ph.D. & LMSW)	
New Patient Visits		**Est. Patient Visits**		**New Patient Visits**	
90792 Intake Evaluation	$240	99212 Level 2	$60	90791 Intake Evaluation	$200
99202 Level 2	$90	99213 Level 3	$90		
99203 Level 3	$125	99214 Level 4	$125	**Est. Patient Visits**	
99204 Level 4	$200	99215 Level 5	$160	90832 30 min. session	$100
99205 Level 5	$225			90834 45 min. session	$120
				90837 60 min. session	$160
Additional Charges (added to above charges)				90839 Crisis Therapy	$160
90833 30 min therapy	$65	90838 60 min therapy	$145	90840 Add'l Crisis Time	$90
90836 45 min therapy	$95	90785 Complex Visit	$10	90874/46 Family Session	$150
*Typical service fees listed; other codes may be used and billed to insurers/patients					

I acknowledge that I have read this agreement. Furthermore, I understand and agree to the conditions specified above.

______________________________ ______________________________
Patient/Client Signature Date

______________________________ ______________________________
Legal Guardian, if patient is a minor Date

______________________________ ______________________________
CFFP Staff Signature Date