Fee Agreement and Financial Policy

ADVANCED PSYCHOTHERAPY SERVICES
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Please review this Fee Agreement and Financial Policy and ask any questions you may have before signing this document. The Fee Agreement and Financial Policy outlines the schedule of fees for services, charges not covered by insurance, and additional fees; additional fees include information pertaining to canceled appointments, missed appointments, past due accounts, etc.

Common Insurance Reimbursement Codes and Self-Pay Amounts:

- 90791: Initial Consultation/Individual (50-60 Minutes) $130.00
- 90834: Individual Therapy (45-60 Minutes) $90.00
- 90837: Individual Therapy (60-90 Minutes) $110.00
- 90847: Couples/Family Session (45-60 Minutes) $120.00
- 90847+99354: Couples/Family Session (60-90 minutes) $150.00
- 90853: Group Session (90 Minutes) $35.00
- 90853: Group Session (If Receiving Additional Services) $25.00

Charges Not Covered by Insurance:

- Evaluations/Assessments: $Price Varies Based on Type and Time
- Urine Handling Fee for Drug Testing (Due at time of sample): $10.00
- Telephone Call with Therapist (Payable on Next Session with Therapist):
  - 5 to 10 Minutes: $20.00
  - 11 to 20 Minutes: $40.00
  - 21 to 30 Minutes: $60.00
- Letter of Support to a Third Party-Simple (1 to 2 Pages): $25.00
- Letter of Support to a Third Party-Complex (2 Pages or More): $50.00
- Report Preparation to Other Professional:
  - $25.00 Record Search/Administration Fee + $50.00 per 15 Minutes of Preparation Time (up to one hour)
    - Additional Preparation Time: $25.00 per 15 Minutes
- Records Request by Patient or Personal Representative (Guardian/Attorney):
  - $3.18 per page for the first 10 pages
  - $0.66 per page for pages 11 through 50
  - $0.27 per page for pages 51 and higher
  - Exception: Social Security Disability
- Records Request by Individual/Entity Other than Patient/Guardian/Attorney:
  - $19.58 record search fee
  - $1.29 per page for the first 10 pages
  - $0.66 per page for pages 11 through 50
  - $0.27 per page for pages 51 and higher
  - Exception: Social Security Disability
- Court Appearance via Phone (Minimum 1 hour, $100/hour): $100.00 Minimum
- Court Appearance (Minimum 4 hours Including Drive Time, $150/hour): $600 Minimum

 Patient Initials _____

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- If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "**EXPRESS**" charge. If the case is reset with notice of less than 72 business-hours, the client will be charged $500 (In addition to Court Appearance Fee). All fees are doubled if the therapist must postpone or interrupt plans to go out of town.

- Any other case management and indirect services outside of our therapy session will be billed at $200.00 per hour, prorated per 15 minutes.
- Insurance Third Party Payers will **NOT** Cover or Reimburse for Missed Appointments
  - Appointments canceled after 5PM the Previous Business Day: $50.00
  - Missed Appointments: $50.00
  - Evaluations/Assessments canceled after 5PM the Previous Business Day and Missed Evaluations/Assessments: $100.00
    - If you are late for a scheduled Appointment/Evaluation/Assessment, the therapist will wait 15 minutes. If not in attendance by then, your therapist may not be able to see you and you will have to reschedule. You will be charged the $50.00/$100.00 Missed Appointment/Evaluation/Assessment Fee.
- The Non-Sufficient Fund (NSF) Fee for a Returned Check Will Incur a Fee of $45.00 per Incident not per Appointment.
- The Non-Sufficient Funds (NSF) Fee for a Declined Credit Card Charge is $10.00 per Incident not per Appointment.
  - We will attempt to process the card once per day for a maximum of three days. It is especially important to ensure funds are available at the time of services.

Insurance Reimbursement:

Advanced Psychotherapy Services accepts and processes insurance payments through a variety of insurance providers. If you are using insurance to pay for services, then we will:

1. Expect and accept payment for copayments, co-insurance, deductible, and fee differences at the time of service.
2. File your claim with the insurance provider
3. Receive payment from your insurance provider

Your insurance company decides what benefits are covered under your plan and whether they will pay for certain services; we do not make these decisions. If your policy does not cover the services provided, you will be responsible for the full amount. We will make a good faith effort to obtain the information pertaining to your policy including eligibility, copayments, deductibles, and coinsurances, but **it is ultimately your responsibility to contact your insurance company** for this information.

- A copayment is the amount of money that you pay up-front before being seen. Copayments are due at the time services are rendered.
- A deductible is the amount of money that you must pay out-of-pocket before the insurance company will begin paying on claims. The deductible is not the full amount of charges. A deductible depends on your plan. Once you have met this amount, insurance will begin paying the allowed amount of charges. If you have a plan that requires you to continue paying after you have met your deductible, you will be paying a coinsurance amount.
- Coinsurance is generally a percentage of the allowed amount after you have met your deductible. For example, if you have a 30% coinsurance, then you will be responsible for 30% of the allowed charges, with your insurance paying the remaining 70%.

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Returning Clients:

If a client terminates treatment for a period of six months or more, they are subject to whatever fee schedule has been enacted since their departure. Those who have returned to therapy after 12 months or more will also be asked to participate in a new intake process if necessary.

Past Due Accounts:

You will be expected to pay for your session in full (if Self-Pay) or your insurance copayment at the time of service. Accepted methods of payment are cash, check, money order, or credit cards. A 3% convenience fee will be added to all credit card payments. Amounts past due by 30 days will incur a $25.00 late fee. Each subsequent 30 days will incur an additional $50.00 late fee.

Appointments/Emergencies:

Appointments are made by calling **440-759-8873**; if I am unable to answer, please leave a message. You can also email **SarahaMartincak.Therapy@Outlook.Com** regarding appointments and general questions.

If you have an emergency, please call **440-759-8873**. Some emergencies may occur when your therapist is unavailable or after business hours. If unable to reach your therapist, please dial 911 or visit your nearest emergency room.

Credit Card on File:

Upon scheduling your first appointment, you have the option to provide credit card information which will be kept on file and used as a form of payment for fees incurred for copayments, deductibles, late cancellations, missed appointments, returned checks, or past due accounts. If your account is not paid in full within 45 days of service, you may be required to provide your credit card information for future sessions and fees. Receipts can be emailed to you if requested.

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number_____

Exp Date_____CCV_____ Billing Zip Code_____

Email for Receipts_____

I authorize Advanced Psychotherapy Services to charge this credit card as needed according to the terms specified in this Fee Agreement and Financial Policy.

Card Holder's Signature_____Date_____

Cardholder's Printed Name_____

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Fee Agreement and Financial Policy

I have read the Fee Agreement and Financial Policy above and have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Saraha Martincak and Advanced Psychotherapy Services. Any and all negotiated exceptions or special arrangements require approval and are not valid unless signed by Saraha Martincak or a representative of Advanced Psychotherapy Services.

Patient/Guardian Signature_____

Patient Name_____Date_____

Clinician/Witness Signature_____

Clinician/Witness Name_____Date_____

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