MENTAL HEALTH PROFESSIONALS

PAYMENT CONTRACT

Client name: _____ d.o.b.: ____/____/____

Bill to: person responsible for payment of account: _____
Address (give complete address; not just P.O. Box): _____
_____
_____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay Mental Health Professionals, Inc. , hereafter referred to as the clinic, the following rates as per our fee schedule: Initial diagnostic appointment $210.00 for doctoral level therapists and $180.00 for masters level therapists. The hourly rates for all subsequent clinical units (defined as 45 – 50 minutes for assessment, testing, and individual, family and relationship counseling) are $175.00 for doctoral level therapists and $150.00 for master's level therapists. A fee of $97.50 is charged for group counseling. The fee for testing includes scoring and report-writing time. Fees for the clinical nurse specialist are $250.00 for a 60 minute intake and $110.00 for a 15 minute medication check.

The clinic reserves the right to periodically increase rates during the course of treatment in accordance with the clinic's overall fee scheduling policy. Professional services may also be terminated at the discretion of the clinic should the aforementioned responsible party fail to honor their financial obligation within a reasonable time frame. This clinic will utilize the services of collections agencies after other reasonable efforts to settle the account have been exhausted. The party responsible for the account shall be responsible for any additional collection commissions, filing fees and/or legal fees associated with accounts that have been forwarded to collections.
A fee of $ 50.00 is charged for missed appointments or cancellations with less that 24 hours' notice.

Part Two Clients with Insurance (Deductible and Co-payment Agreement)

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, co-insurance, and/or deductibles.

Your insurance company may not pay for services that they consider to be investigative, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three All Clients

Co-payments are due at the time of service. There is a 1.5% per month (18% Annual Percentage Rate) service charge on all accounts that are not paid within 60 days of the billing date.

Part Four All Clients

Additional Service Charges (usually not covered by insurance). Clients with be charged for various services provided by their clinician that are not part of their face to face appointments. These include:

- Letters, reports, form completion or telephone calls to non-medical professionals to coordinate care (teacher, social worker, probation officer, attorney, etc.).
- Telephone calls with clients, parents, or other professionals lasting longer than 10 minutes
- Participation (telephone or in person) in meetings (school, social services, corrections, attorney, etc.)
- Letter or report required for government service
- Court testimony and reports required for legal proceeding must be discussed in advance and are billed at full hourly fee, including transportation and wait time. The responsible party will be billed for this service even when the identified client may not have initiated the clinician's testimony.

Continued on reverse side

Part Five:

I authorize Mental Health Professionals, Inc. to keep my signature on file and to charge my credit card listed below for any balance applied to my account that is 60 or more days overdue. Any exceptions to this policy must be approved by the treating clinician.

Credit Card information:

( ) VISA ( ) Mastercard ( ) bank debit card

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card #: _____ Expiration. Date: ____/_____
MM/YYYY

V-Code (See below): _____ Billing Zip Code: _____

(V-Code: the last 3 digits in signature block on MasterCard & Visa)

X_____ ____/____/_____

Cardholder Signature Date

Part 6 Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to Mental Health Professionals, Inc.all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

I HEREBY CERTIFY that I have read and agree to all of the above conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

X_____ Date: _____/____/_____

Person responsible for account: