February 2021

OFFICE FINANCIAL AGREEMENT

For the Practice of Dr. Amy Lynn Fehlberg, PLLC

Patient Last Name: _____ First: _____ Birthdate: _____

Thank you for deciding to work with me for mental healthcare needs. As a condition of your treatment, financial arrangements must be made in advance. My office depends on reimbursement from patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

Patients with insurance understand that services are charged to the patient and that they are personally responsible for payment of all services. Most insurance companies reimburse only a portion of my service costs. It is important that you understand your insurance policy and your available benefits, including the amount of your deductible and when your plan year rolls over. If your insurance company authorizes a limited number of sessions per year, it is your responsibility to keep track of the number of sessions used and to request additional sessions as needed. If you are required to submit information prior to payment, this is your responsibility. My billing department will file your claim with your primary insurance. If you have a secondary insurance you will need to submit information to them on your own. If you are not using insurance, payment in full is expected at the time of your appointment. Regardless of how you choose to pay your co-pays or any costs not covered, you must leave a credit card on file with me. Please keep track of the expiration date of this card and provide me with updated information on or before the expiration of that card. Your insurance reimburses for your therapeutic treatment only (i.e., it does not cover time spent preparing documents, drafting letters, consulting with other professionals, etc.) As a result, services provided outside of regularly scheduled visits may be charged in addition to the service rates listed below. In general, additional fees are based on the amount of time spent providing the requested services. We will discuss additional charges prior to my providing additional services unless services are provided as a result of a crisis / emergency or are requested directly by you. You may be billed for these services.

As a patient in the practice of Dr. Amy Lynn Fehlberg, PLLC I agree to the following: In consideration for the mental healthcare services rendered to me, any member of my family, or any other person at my request, I agree to pay for all services rendered at the rates indicated in the table below. I understand that I am financially responsible for all outstanding charges whether or not paid by the insurance company. At the discretion of this office, a payment plan may be made available for my outstanding charges. All payment plans will be made in writing and require the execution of a separate document by both parties. No oral agreements for payment have or will be made.

Service	**Rate**
Initial Assessment	$200.00
Individual / Family/ Couples Therapy	$170.00 (for 45-60 minute session)
Letter writing / consultation with other professionals	$200.00 per hour
Legal / court related activities	$300.00 per hour

I understand that **missed appointments will be charged at the full rate without any discounts** if they are not cancelled at least 24 hours in advance. A 24-hour notice gives me a chance to allow another patient to use that time, as appointment time is limited. Insurance companies do not reimburse this fee and you will be held 100% responsible for missed appointment fees. If you have questions about being billed for missing a session, you must discuss this with me. My billing staff are unable to help with this issue.

In case of divorced or separated parents, I am aware that often the non-custodial parent is responsible for payment of medical bills, including mental healthcare. However, if the legally responsible party does not respond to our requests for payment, the responsibility for the payment falls to the parent who brings the child for our services.

I understand that there will be an additional $50.00 service charge on all returned checks. I understand that after one returned check, the only acceptable method of payment is cash or credit card.

It is understood that the charges shown by invoices or statements are due and payable in full at the time of services. A monthly service charge of 1.75% (21% per annum) of the unpaid balance may be assessed on all accounts exceeding sixty (60) days past due. Patients with large outstanding balances will have their accounts reviewed and may not be eligible for further services. If accounts are not paid in a reasonable time, collection services will be utilized. I agree to pay court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee of up to 40% of the outstanding balance as compensation to this office for any commission it must pay to a collection agency in collecting any outstanding balance. Furthermore, I agree that this fee is proportionate to the actual damage caused by my nonpayment and is not an excessive estimate of the costs of collection.

I grant my permission to your office to contact me at my home, my place of business, or via my cell phone to discuss matters related to this form. I also agree to let this office leave messages concerning this form on answering machine(s) and voicemails associated with any phone numbers I have provided.

I authorize release of all information concerning my account, including charges billed, payments made, and interest charges, etc. to your office and to any collection agency this office uses. I authorize release of all information concerning my account to insurance carriers for payment. I authorize all insurance payments made on my behalf to come directly to your office.

This agreement supersedes all prior agreements, including any and all mediation or arbitration agreements. I acknowledge that any prior mediation or arbitration agreements signed previously related to financial arrangements are null and void. I acknowledge that I have received a copy of this office's Privacy Policy (HIPAA agreement) and I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of patient, parent, or guardian Date