

Patient Code: _____

FINANCIAL POLICY AND AUTHORIZATION (MEDICARE)

- Contemporary Care does not participate with Medicare.
- It is the patient responsibility to submit claims to Medicare. Invoices and claim forms will be provided by the office.
- Patient is responsible for all costs of their treatment, and will also be responsible for any costs incurred regarding bill collection. Returned checks will be charged the entire amount plus a \$25 fee.
- Invoices will be generated on Mondays the week after each treatment
- Duration of treatment is based on treatment plan set by doctor.
- **TMS Therapy Costs:**
 - Initial Evaluation: \$300
 - TMS Planning: \$300
 - TMS Treatment Sessions: \$228 (*each session*)
 - Follow-up Sessions \$300 - \$450 (*depending on length of session*)
 - Insurance Filing Fee \$100 (*one-time charge*)
 - Recheck of TMS settings \$250
- **Medication Management Costs:**
 - Initial Evaluation: \$300
 - Follow-up Medical Management \$300
- **Cancellations are billed at \$150, if you cancel with less than 24 hours' notice.**
-
- **Payment Options:**
 - Payment may be made by check or credit card. (*for easier processing, you may keep a credit card number on file with us*).
 - Checks should be made out to *Contemporary Care*.

I hereby acknowledge that I have read, understand and agree to this Financial Policy:

Patient Signature

Date

Patient Code: _____

PAYMENT INFORMATION

- Check
- Credit

Credit Card Authorization:

I hereby authorize Contemporary Care to charge the full cost of my treatments to the following credit card:

- Visa
- Mastercard

Card # _____ Exp ____/____

Security # _____ Billing Zip Code _____

Card Holder Signature _____ Date _____

PAYMENT INFORMATION

- Check
- Credit

Credit Card Authorization:

I hereby authorize Contemporary Care to charge the full cost of my treatments to the following credit card:

- Visa
- Mastercard

Card # _____ Exp ____/____

Security # _____ Billing Zip Code _____

Card Holder Signature _____ Date _____

PAYMENT INFORMATION

- Check
- Credit

Credit Card Authorization:

I hereby authorize Contemporary Care to charge the full cost of my treatments to the following credit card:

- Visa
- Mastercard

Card # _____ Exp ____/____

Security # _____ Billing Zip Code _____

Card Holder Signature _____ Date _____