Patient Code: _________

FINANCIAL POLICY AND AUTHORIZATION

(FEE FOR SERVICE)

- Contemporary Care requires payment at time of service.
- Contemporary Care does not accept all insurance, but may provide bills for you to submit to your insurance carrier for reimbursement. (*Contemporary Care does not guarantee that you will be reimbursed by your insurance carrier*).
- 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: $550
  - TMS Planning: $500
  - TMS Treatment Sessions: $400 (*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: $650
  - Follow-up Medical Management $300
  - Psychotherapy $480
- ***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 ____/____

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Card Holder Signature ________________________________ Date ________

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Security # __ __ __   Billing Zip Code __ __ __ __ __

Card Holder Signature ________________________________ Date ________