MD Psychiatry & Emotional Health, PLLC

FINANCIAL AGREEMENT

I acknowledge and understand that I am responsible for all charges associated with any services rendered to me or any individual where I am listed as the responsible party. I hereby agree to pay the insurance deductible and/or co-payment or the self-pay amount as services are provided. **I understand that if I do not provide my insurance information by a minimum of 48 hours prior my initial/follow-up visit, I will be required to pay the self-pay rate at the time of service.** If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of statement. It is also my responsibility to review my insurance coverage and the Explanation of Benefit (EOB) forms I receive from my insurance so I have an understanding of my costs and can track insurance payment for services rendered.

I understand that if I am filing my services rendered through insurance that my claims will be sent electronically to ReLi Med Solutions. ReLi Med Solutions will direct the insurance claim to my insurance company electronically. I understand that my insurance company will obtain information listed on the insurance claim about the diagnosis and the dates of service for psychiatric treatment sessions provided. By my signature below, and as recorded on the HIPPA consent form, I am giving MD Psychiatry & Emotional Health, PLLC permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. Furthermore, I authorize payment of my mental health benefits be made to MD Psychiatry & Emotional Health, PLLC.

Although I have requested MD Psychiatry & Emotional Health, PLLC to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. The fees for services are listed below:

FEES FOR SERVICES (Self-Pay Rates):

MD:

Initial Evaluation (45 min.)- $400.00
Med Management (20-30 min.)- $200.00
Psychotherapy (45-55 min.)- $300.00
MM and Psychotherapy (90 min.)- $600.00
Consult or Professional competency (90-120 min. MD, Attorney, Engineer or Executive) - $800.00

NP/PA:

Initial Evaluation (45 min.)- $300.00
Med Management (20-30 min.)- $150.00
Psychotherapy (45-55 min.)- $200.00
MM and Psychotherapy (90 min.)- $400.00
Consult or Professional Competency (90-120 min. MD, Attorney, Engineer or Executive)- $600.00

CANCELLATION POLICY:

In the event that I need to cancel my appointment, I acknowledge that I must notify the office/provider ***72 hours*** **prior** to my appointment or I may be charged a no-show fee. In the event of an emergency, please contact the office and/or provider as soon as possible to reschedule.

I have read and understand the financial agreement as detailed above. My signature represents my agreement to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier and agree to make all efforts to pay for services rendered in a timely fashion.

Signature: _____ Date: _____
(Patient or Parent/Guardian)

Print Name: _____