IME BEHAVIORAL HEALTH, LLC

FINANCIAL AGREEMENT

By signing below, I am accepting the terms and services and office policy as follows:

THERAPY:
I understand that fees for services are billed at the following rates:
Initial Visit: **$175**
45 – 50 minute Therapy Session: **$125**
45 – 50 minute Family Therapy Session: **$150**

Additional Services such as Telephone Consultations, Letters, Additional Reports, and other fees will be billed at a pro-rate of time based on $175 per hour. Forensic Evaluations, Legal Reports, Testimony and Travel Time are billed at $250 per hour.
_____ initial

MEDICATION APPOINTMENTS:
I understand that fees for services are billed at the following rates:
Initial Visit: **$225**
20 minute med check: **$115**

Additional Services such as Telephone Consultations, Letters, Additional Reports, and other fees will be billed at a pro-rate of time based on $225 per hour. Forensic Evaluations, Legal Reports, Testimony and Travel Time are billed at $250 per hour.
_____ initial

All Missed Appointments or Appointments Not Cancelled within 48 hours will be billed at the rate of $80. Missed or Cancelled Appointments are not Billable to your Insurance company. _____initial

Erica M. Dixon, LCPC, LCADC is contracted with Carefirst, Johns Hopkins Health Plan

Indrani Mookerjee, DSW, LCSW-C is contracted with Carefirst, Medicare, Johns Hopkins Health Plan

Deb Scrandis, PhD, FNP-BC, FPMHNP-BC is contracted with Carefirst, Johns Hopkins Health Plan, Medicare and Medical Assistance.

Christina deGraft-Johnson, LCPC is contracted with Carefirst, Johns Hopkins Health Plan and United Healthcare is pending.

Matthew Stevens, LCSW-C is contracted with Carefirst, Johns Hopkins Health Plan, Medicare and United Healthcare is pending.

We do not have contractual relationships with any insurance company not listed above. If you do have other insurance, we will generate a superbill for you to submit to your insurance carrier in order to receive out of network benefits. This does not waive your responsibility for fees incurred. Please consult with your insurance carrier to determine what services will be covered under your particular plan. By signing below, you agree to indemnify our office from any error or omission in the preparation or filing of your insurance claim. It is your responsibility to make sure that insurance claims have been filed and are complete. If you would like us to file a claim on your behalf, please complete the patient information form completely and do not use nicknames.____initial

All precertification of services and continued certification of services for non contracted insurances are your responsibility. You agree to pay for any services denied due to lack of precertification or required notification to your insurance plan.____initial

Unless otherwise agreed to in writing, I understand that accounts are due on receipt. Interest at a rate of 1.5% per month will be charged to any accounts 90 days past due. If this account is referred to any agency or attorney for collection proceedings, I will pay all costs incurred in the collection of this account including but not limited to attorney's fees in the amount of 50% of your account balance at the time that account is placed.

Signature of Guarantor/Financially Responsible Party Date

Printed Name

Signature of Client Receiving Services Date