

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: **\$145**

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: **\$275**

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 \$275 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 charged directly to you at the rate of \$80. Being 15 minutes late to a Telehealth Appointment also qualifies as a Missed Appointment. Missed or Cancelled Appointments are not Billable to your Insurance Company. _____ initial

Any check that is returned due to insufficient funds will incur a \$35 charge to your account. _____ initial

Erica M. Dixon, LCPC, LCADC is contracted with Blue Cross Blue Shield, and Johns Hopkins Health Plan

Indrani Mookerjee, DSW, LCSW-C is contracted with Blue Cross Blue Shield, Johns Hopkins Health Plan and Medicare.

Deb Scrandis, PhD, FNP-BC, FPMHNP-BC is contracted with Blue Cross Blue Shield, Johns Hopkins Health Plan, and Medicare.

Ana Duarte, PhD, CRNP-PMH is contracted with Blue Cross Blue Shield, Johns Hopkins Health Plan and Medicare.

Christina deGraft-Johnson, LCPC is contracted with Blue Cross Blue Shield, Johns Hopkins Health Plan.

Matthew Stevens, LCSW-C is contracted with Blue Cros Blue Shield, Johns Hopkins Health Plan, and Medicare.

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