# Out of Network/Self Pay Agreement

I, ______________________________________ (client/legal guardian), understand that Serenity Mental Health and Wellness Services an Out-of-Network provider for the insurance companies. I understand my financial obligations to Serenity Mental Health and Wellness Services, LLC and understand that I will be billed for all services provided to myself/my child at the following rate:

- Individual Therapy ……………………………$125.00
- Couples/Family Therapy………………..............$200.00-$250.00

I understand that payments are due ***before*** service date and time and can be made in the following ways:

- Online Banking Transfer (via Zelle for Business) by sending to email serenitymhw@gmail.com

- Debit, Credit Card, HSA or FSA cards (via Ivy Pay, setup instructions will be sent via text)

**Cancellation policy:** 48 hours' notice is required for cancellations to not incur a charge of full session fee.

I understand that my clinician is not paneled with insurance companies and that I may request a specialized receipt for services after paying for my session/s. I understand that I can submit this receipt to my insurance company but that often they will not provide any reimbursement for services. This may be because I do not have a diagnosis or that the diagnosis I do have, they do not cover. It may be because they do not reimburse for out of network providers. Or that they do not reimburse for tele-health. There are many reasons why an insurance company may not reimburse me for sessions I have paid for. Amber has advised me to select to work with her only if this potential reimbursement is a "bonus" for me, rather than financially necessary for these reasons. ______ (initials)

I understand that it is my responsibility to submit the receipts to my insurance company and/or to transcribe them accurately into the software my insurance company provides me. I understand that my insurance company may contact my provider (Kalima Jackson-Wills) for more information to try to justify or reject an insurance claim. I understand that my provider (Kalima Jackson-Wills) wants on my explicit permission to talk with insurance companies and clarity about what I would and

would not like for her to share. I understand that Kalima works for me as a therapist and not for the insurance company or as an advocate for reimbursement. ____ (initials)

I understand that any time I involve my insurance company, even for reimbursement through this special receipt, they can attempt to review all of my clinical records to determine if they think treatment is medically necessary and that they will sometimes reject reimbursement simply because notes were written to support my care, but not to adhere to their specifications about how clinicians document sessions. _______ (initials)

**Payment Agreement**

I understand that these types of fees may be charged to my account; a fee for missed appointments, late cancellations and legal materials and meeting attendance. All fees must be paid before additional appointments can be made. I authorize a release of necessary information to a collection agency if needed. I will be responsible for Kalima Jackson-Wills, MS at Serenity Mental Health and Wellness Services LLC's entire balance, as well as additional legal, attorney and collection costs that arise.

**Late Cancellation/Missed Appointments**

I understand that these types of fees may be charged to my account. The fee for missed appointments and late cancellations much be paid before additional appointments can be made. I authorize a release of necessary information to a collection agency if needed, I will be responsible for Kalima Jackson-Wills, MS at Serenity Mental Health and Wellness Services LLC's entire balance, as well as additional legal, attorney and collection costs that arise.

**Scheduling and Appointments**

I understand that I have a reoccurring date and time for sessions. In the event that I no-show or late cancel for **two or more sessions** without proper notice (48hours) and or previous session fee has not been paid, the agreed upon appointment time may be not be available. I agree to notify therapist of any barriers to keeping my scheduled appointments so that adjustments can be made and or resources can be provided to other services that may be able to accommodate my needs.

_________________________________________ _______________________

Client/Legal Guardian Signature Date