CENTER FOR INTEGRATIVE PSYCHOTHERAPY

AGREEMENT OF PAYMENT

I, _____ , agree that I am fully responsible for fees, which may or may not be covered by insurance, **regarding all the services rendered at the Center for Integrative Psychotherapy, P.C. (CIP) for _____ (patient's full name).**

Please read the following agreement of payment carefully. There are different kinds of insurance coverage for mental health services. Ultimately, it is your responsibility to find out what are the terms of your insurance coverage (What is your deductible, co-insurance, and/or co-payment). Any questions regarding your insurance coverage should be addressed with your insurance carrier prior to the scheduled appointment. However, we will be glad to assist you and try to answer your questions or concerns.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at CIP, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at CIP are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at CIP; or (v) you have chosen not to use your health plan coverage**. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.**
You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be considered a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by CIP**. If you do not provide your updated information within 2 weeks of changing your insurance or by the upcoming appointment you will assume all liability caused by lack of coverage, late filing or non-participation.**

Deductibles and Co-insurance Dues. This section will apply if you are using insurance and you have deductible and/or co-insurance. **Coinsurance** means that you share a percent of the costs of a covered health care service. The amount is calculated as of the allowed amount for the service. For example, if your health insurance or plan's allowed amount for an office visit is $100 and you have a 20% coinsurance, you will pay the therapist $20 and your health plan will pay the therapist the rest of the allowed amount ($80). In mental health, the allowable amount varies according to the type and length of the psychotherapy session. For example, the allowable amount will be different for a session that takes between 38 to 52 minutes (Coded as 90834) compared to one that takes between 53 to 60 minutes (Coded as 90837). A **deductible** is a predefined dollar amount that must be paid by you toward the cost of covered services before the plan begins to pay benefits. When you have a deductible, you are responsible for 100% of the Amount Allowed for a service until you've paid an amount equal to your deductible. After that, your health plan pays the majority of the costs -- perhaps 80% -- but you are still responsible for the remainder (in the form of coinsurance or copayment).

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any

payment is made directly to you for services billed by us, you agree to promptly submit same to CIP until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize CIP to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a financially responsible party, and any remaining balance will be returned to the payer.

I understand that the CIP will be billing my insurance company for psychological or counseling services rendered virtually through telehealth services or in-person. Coinsurance and deductible dues are based upon the charge determination of my insurance carrier. I further understand that all charges that are not covered by my insurance company are my responsibility. Specifically, I will be responsible for any co-insurance and deductibles. All deductible and co-insurance balance payments are due immediately upon receipt of billings. I will be billed to my billing address for the outstanding monies. I can pay with cash, check or credit card. I understand that if I have not paid the balance in fifteen days (15) from the due date in the invoice sent to me or by my next appointment (whichever one is first), I will have all my appointments cancelled until payment is received by CIP. I also understand that if CIP is unable to collect payment, my account will be in default and may be referred to a collection agency.

Signature (Patient, Parent/ Guardian or Party Responsible)

Co-payments. This section will apply if you are using insurance and you have co-payments. A copayment (or copay) is a fixed-dollar amount that you pay each time you have a psychologist's or counselor's visit. All insurance co-payments are due at the time of service, that is, before each therapy session. No patient is authorized to run a balance by accumulating unpaid copayments, unless it is formally approved by the administration**. I understand that after two unpaid co-payments, the therapy sessions will be stopped temporarily until the total balance is paid in full.**

Signature (Patient, Parent/ Guardian or Party Responsible)

Missed Appointments and Late Cancellations. Missed psychotherapy appointments and late cancellations lower the effectiveness of the therapeutic process, prevent other patients to use the service, and constitute a financial burden to the organization. The CIP requires that you notify the office of any cancellation no later than one business day before your appointment. Missed appointments are not covered by your insurance, and you will be responsible for its coverage. I understand that once an appointment is scheduled I will be expected to pay for it unless I provide twenty-four (24) hours advance notice of cancelation, or unless my clinician agrees that I was unable to attend due to circumstances beyond my control. For example, missed appointments due to sudden illness, family emergencies or inclement weather will not be charged. I understand that if I cancel with less than twenty-four (24) hours to the appointment or if I fail to show for a scheduled appointment, I will be charged for the session. The dues to be paid for a missed or broken appointment are as follows: **$50 each for the first and second missed/broken appointment, and $100 each for the third and fourth missed/broken appointment. After the fourth violation my treatment will be discontinued (policy effective as of October 3rd, 2019. Previous fees are subject to former agreement of payment).**

Signature (Patient, Parent/ Guardian or Party Responsible)

Full Payment (No insurance). If you are not using insurance, the CIP requires that charges rendered by our clinicians be paid for at the time of service unless other formal arrangements have been made with our administration. The fee per session is $175 for initial intake, $ 150 for a 45 minute session, and $ 170 for

a 60 minute session. (Fees are subject to change without previous notification) Your fees may vary if you made a formal agreement with your therapist for different session fee.

Signature (Patient, Parent/ Guardian or Party Responsible)

Payment Guarantee. There are a number of circumstances that delay the payment of psychological and counseling services delivered to you or agreed with you: Deductibles dues, co-insurances dues, not bringing money to pay for co-payments, less-than-24-hours-cancellations and missed appointments. In order to best insure more prompt payment of our services we ask that you pay for your invoices upon receipt, in order to avoid appointment cancellations, treatment suspension and being sent to collections. I understand my signature also requests that payment be made and authorizes the release of necessary information to pay the claims by my insurance carrier(s).

Payment by Check. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $25.00, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize CIP, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee.

Additional Charges. Patients may incur and are responsible for the payment of additional charges at the discretion of CIP including but not limited to: (i) charges for a missed appointment without 24 hours advance notice; (ii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment (iii) charges for copying and distribution of patient medical records; (iv) charges for extensive forms preparation or completion requested by the patient; or (v) any costs associated with collection of patient balances, all as allowed by law.

Non-Payment on Account. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that CIP has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Withdrawal of Care.

Financially Responsible Party. If this or a separate CIP Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as a financially responsible party, you hereby guarantee the full and prompt payment to CIP of all indebtedness of patient to CIP, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by CIP in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no

obligation on the part of CIP at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of the financially responsible party.

TELEHEALTH SESSIONS FINANCIAL AGREEMENT

I, _____acknowledge that I have been informed that the telehealth sessions that I requested for myself or my child _____, might not be covered by my insurance company, and I have called my insurance company to confirm coverage of telehealth service. In the event that my services are not covered, I am assuming full monetary responsibility for the sessions which rates will be accommodated to my insurance contractual rate of an in-person session.
I, or my financially responsible Party will call 610-432-5066 prior to my appointment, and will provide a credit card to the Center for Integrative Psychotherapy for payment of potential balances I may accrue and/or insurance assigned cost share per session.
The telehealth appointment will be kept under the same policies of any in office appointment and cancellations will require at minimum 24 hours prior to appointment.
I am appointing_____ as my financial responsible party.

PATIENT AUTHORIZATION

I have read and agree to the above statements

I authorize payment through the provided credit card for telehealth services provided by CIP. I confirm calling my insurance plan and verifying coverage is part of my plan.
My signature below certifies that I have read and agree to all polices, authorizations and payment requirements. I understand that the stated polices apply to all telehealth services rendered.

I certify that I have read and fully understand, or have had explained to my satisfaction, the above statements. **By my signature, I hereby affirm to all of the terms and conditions set forth in the above paragraphs and agree to be bound by this contract.**

Patient Name (print): _____ DOB:

Patient Signature: _____ Date:

_____ _____

(Date) (Patient, Parent/ Guardian or Party Responsible)

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