

## **IH&WB Fee Schedule/Financial Responsibility**

*Innovative Health and Well-Being PLLC*

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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### ***Patient Agreement of Financial Responsibility.***

Thank you for choosing Innovative Health and Well-Being PLLC for your Psychiatric Mental Health treatment. This document/policy will outline what your financial responsibilities are. Please read this document carefully and sign on the last page.

It is your responsibility to ensure that Innovative Health and Well-Being PLLC has your most up to date and accurate health insurance information, mailing address, and contact phone numbers. It is your responsibility to know the details of your health insurance plan, including benefits, and out of pocket coverage details. If you are uncertain of the specifics or have additional questions regarding your plan coverage, please contact your health insurance company. Your health Insurance policy is a contract between you and your health insurance company/employer and we are unable to change any of the plan specifics and do not have any control over the amount of your copay or deductible.

### **Rates:**

*Self Pay:* These rates typically apply to those who may have health coverage, but if your insurance is out of network the patient will be considered self-pay and charged directly. While services are rendered out of pocket we can provide documentation for possible reimbursement for you to submit to your health insurance company.

Please note, if you already have a negotiated rate with Melissa Gregory this will be grandfathered into the practice for telehealth or in person appointments and will be documented appropriately to your chart.

- Initial Evaluation \$300
- 60 min service \$200
- 45 min service \$150
- 30 min service \$100
- 15 min service \$50

Missed appointments/late cancellation fee- will be billed for the negotiated out of pocket rate discussed with your provider.

Paper Documentation fee-(includes:Letters/notes for patient of one page)- \$20

Document completion of more than one page- (Includes:FMLA,disability etc.)-\$40

Phone Call

15 min - \$50

30 min - \$100

45 min - \$150

60 min - \$200

IEP/School/Hospital/other meetings outside of regular/routine follow up appointments that require a provider's time via phone/telehealth or in person.

15 min-\$50

30 min-\$100

45 min -\$150

60 min-\$200

Insurance: Carries include; Blue Cross Blue Shield, Tufts (Commercial only, does not apply to MassHealth) and Optum (Harvard Pilgrim, Allways,UBH) and Medicare.

Please note all patients are responsible for their designated copay based on their insurance company. As well as any remaining deductibles on your account after your insurance is billed- this will be out of pocket and at the responsibility of the patient.

Telehealth or in-person appointments (billed to insurances)

- Initial Evaluation -\$400
- 45-60 min service - \$300
- 30 min service - \$200
- 15-29 min service - \$150

- 45 min psychotherapy services - \$200
- 30 min psychotherapy services - \$150

Missed appointment/late cancellation fee -we ask for 24 hours notification for cancellation of appointment, otherwise the following fees will be charged to the patient's account. Any missed appointments cannot be billed to insurance. The responsibility of this fee will be out of pocket and at the responsibility of the patient.

*Out of pocket responsibilities from the insured patient are as follows;*

Missed appointment fees are as follows:

Initial Evaluation 60 min - \$300

60 min service - \$200

45 min service -\$150

30 min service -\$100

15 min service -\$50

Paper Documentation Fee-(includes:letters/notes for patient of one page)-\$20

Document completion of more than one page (includes:FMLA,disability etc.)-\$40

Phone Call:

15min -\$50

30min -\$100

45min -\$150

60min -\$200

IEP/School/Hospital/other meetings outside of regular/routine follow up appointments that require a provider's time via phone/telehealth or in person.

15min -\$50

30min -\$100

45min -\$150

60min -\$200

This information is subject to change, and you will be notified via documentation in the patient portal in the event that it does.

Consent to bill Insurance- for those who are insured, by signing below this also certifies that you have Insurance coverage and IH&WB may use any clinical/billing data to send to their Insurance

company for the purposes of obtaining reimbursement for services, authorizations and determining eligibility.

By signing below, I have acknowledged that I have read and understood the Innovative Health and Well Being Patient Agreement of Financial Responsibility Policy.

Patient

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian if the patient is under the age of 18 years old.