****

 **BROOKHAVEN CENTER**

**FEES AND PAYMENT POLICIES**

***Revised 07/2020***

 Dr.’s Doctoral Master’s

 ***Office Fees\****  Hoffman Prepared Prepared

|  |  |  |  |
| --- | --- | --- | --- |
| Initial Evaluation (90791) | $245 | $225 | $190 |
| Crisis Services (90839) 60-90 min. | $248 | $220 | $186 |
| Full Individual Psychotherapy Appointment (90837) 53+ min. | $238 | $195 | $178 |
| 3/4 Individual Psychotherapy Appointment (90834) 38–52 min. | $165 | $150 | $135 |
| 1/2 Individual Psychotherapy Appointment (90832) 15-37 min. | $135 | $115 | $95 |
| Marital/Family Psychotherapy Appointment (90847) 25+ min.  | $210 | $175 | $150 |
|  First HourPsychological Testing Add’l Hours | $207$157 | $190$145 | $155$118 |
| Group Psychotherapy (90853) | $90 | $80 | $58 |
| Research/Report Preparation/Consultation (Per Hour) | $165 | $150 | $135 |

*\*Aetna, BlueCross/Blue Shield, Medicare, and TriCare Fee Schedules are honored.*

***Administrative Fees***

Monthly submission fee for out of network insurance plans $15

 Insufficient funds/returned check fee (in addition to bank charges) $30

 Rescheduling fee (in the event of frequent rescheduling requests) $15

 Administrative charge for out of network insurance company issues $15 min/$50 per hr.

 Processing financial information requests $15 min/$50 per hr.

 Resubmission of claims when due to inaction of patient $15 min/$50 per hr. .

 *Late cancellation/No Show $Full appointment Fee*

 *Late payment fee* $30

 *Late to Appointment Fee -Difference between a full appointment fee and partial appointment fee.*

***PATIENT COPY***

 *Rev. 7/2020*

**HIPAA NOTICE**

We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. A copy of this form is available for review in our office. If you desire a copy to take with you, one will be provided.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

**Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that…
**(Initial all six boxes):**

\_\_\_\_ I understand that if I have a non-covered service for which my insurance carrier

will not make payment, I agree to be financially liable to make payment for any charges incurred for these services.

\_\_\_\_ I understand that I will be responsible for all fees incurred if this visit or any other

 service precedes the effective date that has been assigned to my enrollment or

 my dependent’s enrollment or occurs after termination of coverage.

\_\_\_\_ I understand that I will be financially responsible for any administrative charge if

 my insurance has lapsed due to non-payment which delays our payment or

 requires rebilling, or if I fail to let my clinician know of any insurance changes

 prior to them taking place.
\_\_\_\_ I understand that I will be responsible when an insurance company will not pay a

 benefit or contracted claim, or if the insurance company requests money back on

 a previously paid claim. There can be several reasons why the claim is denied or

 reversed:

 1) The service was not covered under the patient’s health insurance contract.
 2) The claim was allegedly received in an untimely manner.
 3) The service was considered as not being medically necessary.
 4) There is another insurance company that is primary.
 5) The procedure or service submitted is included with another procedure or service being billed at

 the same time.
 6) The patient’s policy was terminated with NO COBRA continuance.
 7) The medical condition was deemed by the insurance company as being pre-existing.
 8) The patient’s policy is new and not effective on the date services were provided.
 9) Authorization or Precertification was not obtained prior to rendering the service.
 10) Benefits ran out. In other words, the patient may have been limited to a certain number of visits.

 11) The patient’s insurance policy is not in effect at the time of service.

 12) Patient did not respond to insurance company for coordination of benefits.

\_\_\_\_ I understand that any missed appointments/ late cancellations (less than 24 hours) will be

 charged at the full office visit rate according to the fee schedule and is my responsibility.

\_\_\_\_ I understand that treatment may be interrupted/postponed if my account is not paid in a

 timely manner and a credit card may need to remain on file in order for treatment to

 continue.

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**SIGNATURE DATE**

*Financial Responsibilities of the Patient*

Each patient is financially responsible for all office charges incurred in his or her treatment. Filing fees will be assessed for “out of network” submissions. This office will not assume responsibility for tracking managed care documentation, except when we are an in-network provider. If *the patient’s* insurance carrier requires *the care to* be “managed”, *the patient* is responsible for overseeing all exchanges of information – including the pre-approval of additional appointments. Documentation, including mandated treatment plans and updates, requiring a psychotherapist’s attention will be handled during an appointment.

**PAYMENT AGREEMENT**

I (we) have read pages 1 - 3 of “Brookhaven Center Fees and Payment Policies” and have received a copy for my (our) own reference if requested. **Payment is expected at time of service or to be paid-in-full on a monthly basis.**

In order to keep my account up to date, I/we elect to:

* Make payment by check or cash at the beginning of each visit.
* Make monthly payment by credit card/debit card which will remain on file

 at Brookhaven Center during the span of my/our appointments.

* Make payment by check upon presentation/receipt of statement. Payment

 to *be* received by Brookhaven Center by the 20th of the month of the dated

 statement. *(****Payments received after the 20th day of the month will be***

 ***assessed a $30 late fee.)***

  Maintain a credit balance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Date**

*Monthly statements will be mailed upon request, or in the*

*event of an outstanding patient co-payment balance.*

***OFFICE COPY – PLEASE RETURN***

 *Rev. 7/2020*