Professional Services Agreement

Thank you for choosing our *[practice name or clinician's name]* for your counseling needs. Our goal is to provide you with the best service possible so that you can receive hope and healing. We look forward to working with you to improve your life and your relationships.

For mental health service to be most effective, it is essential to have these services coordinated with other health care providers. Information will only be shared in accordance with the Privacy Policies of this Practice. For any person or institution that is not directly related to treatment, payment of services or health care operations of this Practice, all protected health information will be kept confidential UNLESS you sign a release authorization. However, all health care providers are legally required to report and release the following information without specific authorization: Suspected physical/sexual abuse and/or neglect of a child or elderly person, to prevent injury to self or others, in a medical emergency to save lives, or if ordered by the court.

This document is an agreement between *[practice name or clinician's name]* and the Client and/or the Client's Guarantor ("You"). In consideration of the health care services provided to you or the Client and on all other accounts for future health care by this Practice, you agree as follows:

1. CONSENT FOR TREATMENT. You consent to mental health care as provided by *[practice name or clinician's name]* as directed by the mental health professional. You understand that due to factors beyond our control, such benefits and desired outcomes cannot be guaranteed. A variety of treatment methods will be used to provide relief of your symptoms and to improve coping and problem-solving skills. You agree to accept the risks that might result from non-compliance to our treatment recommendations.

2. FINANCIAL AGREEMENT. You agree to pay *[practice name or clinician's name]* for services at the time they are rendered. If you wish to use health insurance, our services may be covered in full or in part by your health insurance provider or employee benefit plan. Please call your insurance company or employer prior to receiving services to check your benefits and coverage levels. It is your responsibility to understand your benefits before receiving services from us. Here are some questions you may want to ask your insurance provider or employer:

- Do I have mental health insurance benefits in my plan?
- Has my deductible been met? If not, what can I expect for my out-of-pocket expenses?
- How much is my co-payment for each session once my deductible is met?
- How many sessions per year does my health insurance plan allow?
- Is an authorization required to receive services?
- Do I have any EAP (Employee Assisted Program) authorizations available?

As a convenience to you, we can bill your insurance company for the services we provide to you. You are financially responsible for charges that are not covered under your insurance plan. All required co-payments, coinsurance and deductibles are due at the time of service or when we receive an Explanation of Benefits (EOB) statement from your insurance company.

A financial deposit in the form of a valid credit card will be required and kept on-file to pay for services and fees. Service fees will be charged to your credit card at the time services are rendered or when we receive notice from your insurance company that you have out-of-pocket expenses such as co-payments, deductible amounts or co-insurance amounts due to us. You agree to pay 1.5% interest per month (annual percentage rate of 18%) of the unpaid balance if your account becomes more than 30 days past due from the date of the invoice. Acceptable forms of payment are cash, check, credit card (Visa, MasterCard, American Express or Discover), HSA or FSA debit cards. Should collection

become necessary by legal suit or other means, you will pay all costs of collection including attorney fees, court costs, including charges and collection agency fees, with or without suit.

3. INSURANCE SUBMISSION AND ASSIGNMENT OF BENEFITS. As a convenience to you, we can bill your insurance company for each service. You authorize *[practice name or clinician's name]* to apply, on your behalf, to Medicare, Medicaid or any other insurance company for payment of our health care services. You confirm that the information you have provided about your healthcare insurance provider is complete and correct. Your authorized insurance, health plan, or statutory benefits, settlements and judgments to which you are entitled in connection with your healthcare services are to be paid directly to *[practice name or clinician's name]*. In consideration of the health care services provided, you give *[practice name or clinician's name]* an irrevocable assignment to all rights you have in your insurance, health plan, statutory benefits, settlements and judgments for which you are entitled, as necessary for payment for your health care service. You agree that you are financially responsible for charges that are not covered by this assignment and that you are responsible for satisfying any conditions necessary for insurance or health benefits.

4. CO-PAYMENT COLLECTION. Per your contract with your insurance company(s), all co-payments must be satisfied during each and every visit. There can be no exceptions due to legally binding contracts and uniform compliance rules.

5. INSURANCE PLAN RESTRICTIONS. You understand it is your responsibility to contact your insurance company regarding your plan benefits and exclusions. Exclusions may include, but not limited to, whether the Mental Health Provider you are scheduled to see is a provider for your plan, whether certain services are covered benefits, and if your plan requires a referral before seeing a specialist. Some plans have reduced benefits for restrictions, while others simply refuse to pay if you receive services outside of your contract. You are also responsible for all co-payments, deductibles and other charges not covered by your insurance as specified in your insurance plan contract. We will not balance bill you for amounts that are not covered or allowed by Medicare, Medicaid or your insurance company.

5. SECONDARY INSURANCE. Having more than one insurance provider DOES NOT necessarily mean that our services are covered 100%. Secondary insurers have specific guidelines, stated in your contract with them, for what they will consider for payment in coordination with your primary insurance company’s payment. We bill your primary and secondary insurance carrier as a courtesy. You are responsible for any balances that result from these billings. If your insurance carrier(s) do not pay after 45 days, we may return the balance due to your responsibility. Subsequent insurance billing may be subject to a billing fee of $5.00 per claim.

6. DIVORCE DECREES. *[practice name or clinician's name]* is NOT a party to your divorce decree. Adult clients/clients are responsible for their bill at the time of service. The responsibility to pay for services to minor children rests with the accompanying adult. If the divorced couple is splitting costs, one person must take responsibility for bringing the child to their appointments, coordinating the insurance benefits between parties, payment of services and keeping track of payments and other documentation related to the services provided.

7. MINOR CLIENTS. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless services have been approved by the parents (or guardians) and payment has been made before or at the time of service in accordance with item number 3 above.

8. RETURNED CHECKS AND CREDIT CARD DENIALS. If a check has been returned for insufficient funds or a credit card transaction is declined, *[practice name or clinician's name]* will reverse the payment amount and add a $30.00 service fee to cover our costs.

9. MISSED OR CANCELLED APPOINTMENTS. When you make an appointment, we reserve that time for you. When you miss or cancel your appointment, it takes away precious time the mental health provider could be spending treating another client. BE ADVISED THAT *[practice name or clinician's name]* HAS A VERY STRICT POLICY AND WILL CHARGE A $75.00 LATE CANCELLATION OR MISSED FEE IF 24 HRS ADVANCED NOTICE IS NOT GIVEN.

10. IN CASE OF EMERGENCY. In the event of an emotional, behavioral, medical crisis or life-threatening emergency call 911 or go to the nearest emergency room. BE ADVISED THAT *[practice name or clinician's name]* DOES NOT PROVIDE 24 HR CRISIS SERVICES.

11. SPECIAL REQUESTS. *[practice name or clinician's name]* reserves the right to charge additional fees for special requests such as, but not limited to: telephone consultations, letters, billing summaries, transportation costs and court appearances you request we make on your behalf. Our hourly rate for such appearances is $120 per hour.

BY SIGNING, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THESE TERMS, YOU SHOULD RETAIN A COPY OF THIS DOCUMENT, AND THAT YOU ARE THE CLIENT, THE GUARANTOR, THE CLIENTS LEGAL REPRESENTATIVE, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT THESE TERMS.

Client's Name:

Guarantor/Legal Representative Name (if applicable):

Your Relationship to Client: (Self, Spouse, Mother, Father, Grandparent, etc.)