HEALTHY SYNERGY
psychological services

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Germantown, MD 20876
301-569-6326 (office)
301-569-6329 (fax)
www.healthysynergypsych.com

Financial Agreement

Name of Client: _____ **DOB:** _____

Agreement:

- ❑ **I request that Healthy Synergy Psychological Services, LLC, provide services to me and I agree to pay the fees in accordance with the fee schedule listed below, or if I am using insurance, any fees determined by my insurance company.**
- ❑ I agree that this financial relationship with Healthy Synergy Psychological Services, LLC, will continue as long as the practice provides services to me or until I inform the practice, in person, by telephone, or by mail, that I wish to end treatment, and my financial obligations to Healthy Synergy Psychological Services, LLC have been met. I agree to meet with the provider at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

Payment:

- ❑ I understand that payment in full is due at each visit. Forms of payment accepted include cash, check, or credit/debit card (Visa, MasterCard, American Express, and Discover). I understand and agree that I am charged directly and I am personally responsible for all services rendered to me (or the minor for whom I am responsible). I also understand that the fee for returned checks is $45.
- ❑ I agree that if I default on payment and my account is sent to collections, 35% will be added to the total outstanding balance and I will be liable for these collections costs, attorney fees, and any and all court costs resulting.
- ❑ I understand that treatment may end if payment is not made or the payment agreement is broken.

Cancellations:

- ❑ **I understand that I will be charged a $100.00 fee for any missed sessions not cancelled outside of 24 hours (not including sickness, family emergency, or weather) in advance beyond a one-time unexcused missed session per year (year defined from therapy start date).**
- ❑ I understand that my insurance company will not reimburse costs incurred for a missed session.

Insurance:

- ❑ I understand that my assigned therapist is in-network for all Maryland Medicaid, Medicare, Cigna, and BCBS policies (not including policies through Beacon Health/Value Options).
- ❑ I understand that certain information may be required by third party sources for the purpose of treatment, payment (including collections of past due accounts) and healthcare operations.
- ❑ **I understand that I am responsible for all amounts not covered by my insurance, such as copays, coinsurances, unmet deductibles, and other non-covered services.**
- ❑ I will inform Healthy Synergy if there is a lapse in my coverage or a change to my policy. If I do not, I understand that I will be responsible for any costs accrued during that period.
- ❑ I further understand that my account will be sent to collections if a payment is not made on all balances within 90 days.

Out of Network:

- ❑ I understand that Healthy Synergy Psychological Services, LLC, is an out-of-network provider for all health insurance plans other than those listed above. The practice will not bill any insurance carrier for the services you receive and will provide you with an invoice for your services that will include the standard diagnostic and procedural codes for billing purposes, the time met, and payments made. This invoice may be used to apply for reimbursement from your health insurer.

Out of Network Schedule of Fees:

Initial Therapy Intake (60 - 120 min)	$225.00	Therapy Session (45 min)	$110.00
Therapy Session (90 min)	$225.00	Telephone Consultation	$65.00/15 mins prorated*
Therapy Session (60 min)	$200.00	Report Preparation	$65.00/15 mins prorated*
Therapy Session (45 min)	$180.00		
Cancellation fee: $100.00 for session not cancelled outside of 24 hours of the scheduled appointment**			

***The first 10 minutes of telephone consultation and report preparation are free. Following that, extra minutes will be prorated at a rate $42.50 for each additional 15 minutes.**

****One exception in cancellation policy allowed per year.**

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client **Date**