PAYMENT CONTRACT FOR SERVICES

Wellspring Healing Center, LLC
704 N CONGRESS ST #3 YPSILANTI, MI 48197

Name of Client(s): _____

Bill to: Person responsible for payment of account: _____ _

Address (if different than client's mailing address):

_____ City: _____ State: _____ Zip: _____ _

Part One Sliding Fee Scale

My gross annual income (yearly before taxes of all people contributing to household expenses): $_____

The number of dependents in my family (household): _____ Sliding scale fee per appointment: $_____

Gross Annual Income		Number in Family 1-2	3-4	5-6	7+	Gross Annual Income		Number in Family 1-2	3-4	5-6	7+
Less than	$34,999	**$60**	$60	$60	$60	$70,000	$74,999	$100	$95	$90	$85
$35,000	$39,999	$65	**$60**	$60	$60	$75,000	$79,999	**$105**	$100	$95	$90
$40,000	$44,999	$70	$65	**$60**	$60	$80,000	$84,999	$110	**$105**	$100	$90
$45,000	$49,999	$75	$70	$65	**$60**	$85,000	$89,999	$115	$110	**$105**	$100
$50,000	$54,999	$80	$75	$70	$65	$90,000	$94,999	$120	$115	$110	**$105**
$55,000	$59,999	$85	$80	$75	$70	$95,000	$99,999	$120	$120	$115	$110
$60,000	$64,999	$90	$85	$80	$75	$100,000	$104,999	$120	$120	$120	$115
$65,000	$69,999	$95	$90	$85	$80	$105,000	& above	$120	$120	$120	$120

Special circumstances which may interfere with my ability to pay the fee (i.e.: financial hardship due to medical expenses):

_____

Part Two Fees for Professional Services

I (we) agree that the fee per session will be $_____

Part Three Clients with Insurance (Deductible and Co-payment Agreement)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

NOTE: These are estimated amounts and are not guaranteed by your insurance amounts policy.

$ _____ Deductible amount (paid by insured party)

$ _____ Co-payment per visit (_____% per clinical session) for the first _____ visits.

$ _____ Co-payment per visit (_____% per clinical session) up to _____ visits.

The policy limit is _____ visits per year; _____ visits per lifetime of policy.

Part Four All Clients

I hereby certify that I have read and agree to the above conditions.

Person responsible for account: _____ Date: _____
Signature