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SERVICE CONTRACT & FINANCIAL POLICY

Welcome to Wellspring Healing Center, LLC (WHC). This document contains important information about our professional services and business policies. We ask that you read it carefully and sign it as an acknowledgement of your agreement to abide by these policies.

Services

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular issues that the client brings. There are a number of different approaches, which can be utilized for the issues you hope to address. It is not like visiting a medical doctor, in that psychotherapy requires a very active effort on our part. In order to be most effective, it typically requires assignments, homework, or activities outside of your sessions.

Appointments

The duration of a session is typically 45-50 minutes. If you and your therapist choose to extend the length of your sessions, you will be billed accordingly, for each additional minute, at the established rate for a regular appointment. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hour advance notice of cancellation. Missed appointments or late cancellations will be billed to you at the rate of $60 per session.

If you do not arrive within the first 20 minutes of your appointment time, it will be cancelled and you will be billed $60. A prorated fee will be billed to you at the established rate for telephone consultations that exceed 10 minutes. Your insurance company **does not** cover phone consultations, missed or cancelled appointments.

Charges, Payment and Insurance Reimbursement

Payment is due at the time of the appointment unless other arrangements have been made with your therapist. If you have a health insurance policy, it may provide some coverage for mental health treatment. As a service to you, we will bill insurance companies and other third-party payers, but cannot guarantee or be responsible for the collection of such payments. Bear in mind that you are responsible for any amount not paid by your insurance policy, all co-payments, and deductibles. Ultimately it is your responsibility to make sure you are taking the proper steps to obtain reimbursement from your insurer. Telehealth is covered under most plans. We will need to make a copy of your insurance card and driver's license/identification at the time of your initial appointment.

Third Party Authorization

Please be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis, date(s) of service, or additional clinical information such as treatment plan, summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files and will be computerized. All insurance companies claim to keep such records confidential, but once they obtain the records, this office is not liable for the way they handle the information. It is important to remember that you always have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage.

Billing Policies

- A $25.00 fee will be assessed to your account for every check returned to us for insufficient funds.
- A $10.00 fee will be assessed to your account for each visit that payment or insurance co-payment is not paid at time of service.
- A $20.00 rebilling fee will be assessed each month a payment is not received on your account balance.

- A claim will be filed with your insurance company for each visit, free of charge. However, a $10.00 rebilling fee will be assessed to resubmit claims that have been rejected due either to the client's request to resubmit previously rejected claims, or the client's failure to provide accurate information.
- WHCreserves the right to forward any client's billing information to a collection agency if it is deemed that the account has been in default of the payment obligations.

Contacting Your Therapist

You may call WHC 24-hours a day. You may leave a message, including cancellations, for any therapist. The answering system records the day and time the call came in. Your therapist will not accept phone calls when with a client. Please note phone calls, SMS, and email messages are not secure and you assume the risk to your privacy if you contact your therapist with these methods. Please use the TherapyNotes patient portal for confidential messages.

If you have an emergency, please go to your nearest emergency department.

Therapists do not accept friend requests from current clients on social media to maintain our respective privacy.

Release of Authorization to a Third Party

I authorize WHC to disclose case records (diagnosis, date(s) of service, case notes, psychological reports, testing results, or other requested material) to a third party or insurance company for the purpose of receiving payment directly to WHC. I authorize the therapist at WHC, to disclose case details to a supervisor for consultation where you are not identified by personal health information identifiers.

Person(s) responsible for account: _____
(Please print full name)

Consent to Treatment

I/We consent to enter treatment provided by a therapist at WHC. I understand that the therapist may terminate treatment if I am physically or verbally abusive, attend a session under the influence, engage in illegal acts at the center, or refuse to follow treatment recommendations, or the center's policies.

Acknowledgement of Receipt of Privacy Practices

I certify that I have read and agree to the conditions stated above. I acknowledge that I have received a copy of this form and the Notice of Privacy Practices.

Client's Printed Name: _____ Date: _____

Client Legal Signature: _____ Date: _____

Add'l Client Printed Name: _____ Date: _____

Add'l Client Signature(s): _____ Date: _____

Add'l Client Printed Name: _____ Date: _____

Add'l Client Signature(s): _____ Date: _____

Add'l Client Printed Name: _____ Date: _____

Add'l Client Signature(s): _____ Date: _____

Add'l Client Printed Name: _____ Date: _____

Add'l Client Signature(s): _____ Date: _____

Signature of therapist: _____ Date: _____