EMERSON DELACROIX, MACP, RYT-200, LLP | ROSE BENJAMIN, LMSW
704 N. CONGRESS ST. SUITE #3 YPSILANTI, MI 48197 | FAX: 734-573-6008
wellspringhealingcenter@gmail.com | www.wellspringhealingcenterllc.com

HIPAA PAYMENT CONTRACT FOR SERVICES

Part One: Your Information:

Preferred Name(s) and Pronouns of Client(s): _____

_____

Bill to: (Legal name of Responsible Party for payment of account): _____

Address (if different than Client's mailing address): _____

City: _____ State: _____ Zip: _____

Email: _____ May we send session reminders to your email? Yes: ___ No: ___

Phone: _____ May we text you at this #? Yes: ___ No: ___ May we leave Voicemails? Yes: ___ No: ___

Phone: _____ May we text you at this #? Yes: ___ No: ___ May we leave Voicemails? Yes: ___ No: ___

Emergency Contact: (*By filling this out, you agree to allow me to contact them only in the event of an emergency)*

Preferred First & Last Name: _____ Relationship to Client(s): _____ Phone: _____

If you are planning to pay out-of-pocket, please skip Part 2 and complete Part 3: Sliding Fee Scale, on the back.
If you'd like to use your BCBSM or BCN insurance, please continue to Part 2.

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

Please provide an ID and Insurance Card by photo ahead of the session, or bring to your first session.

Estimated Insurance Benefits NOTE: *These are estimated amounts and are not guaranteed by your insurance amounts policy. If you do not know, it may take up to one month for your claims to return with a determination. You may contact your insurance provider on the back of the card to verify your eligibility for Outpatient Mental Health Services.*

$ _____ Deductible amount (paid by insured party)

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

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

Member/Enrollee ID: _____ Group #: _____ Legal Gender Marker F___ M ___ O ___

Insured party: Self __ Other (include name of Insured Party): _____

DOB of Insured Party (if not self): _____Gender Marker of Insured Party (if not self): F___ M ____ O ____

Address of Insured Party (if not self): _____

City: _____ State: _____ Zip: _____ Relationship to Insured Party _____

Part Four: All Parties

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

Please Note: Your signature on this form also provides a release to your PCP if required by your insurance plan

Responsible Party/Client Signature: _____ Date: _____

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

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

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

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

WELLSPRING HEALING CENTER, LLC
psychology, yoga, healing

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Part Three: Sliding Fee Scale

Without a sliding scale, each 45-minute-session is billed $140. Each minute, after 45 minutes, is billed $2.80 per minute. Because Wellspring Healing Center, LLC bills to insurance companies, we are required to charge the same amount to our private pay clients. We are allowed to offer a sliding fee scale by gross annual income. Please use the chart below to determine your fee per session. The left column is your household annual income before taxes and other deductions. (A household is the number of people who share a budget, not necessarily the number of people who live together.) Follow the annual income row over to the right until you reach the column with the number of people in your household. Please circle the sliding fee scale amount for which you qualify. (Note all missed sessions, or canceled in less than 24 hours are billed $60.)

Gross Annual Income	1 person	2 people	3 people	4 people	5 people	6 people	7+ people
Less than $14,999	$40	$40	$40	$40	$40	$40	$40
$15,000 - $19,999	$45	$40	$40	$40	$40	$40	$40
$20,000 - $24,999	$50	$45	$40	$40	$40	$40	$40
$25,000 - $29,999	$55	$50	$45	$40	$40	$40	$40
$30,000 - $34,999	$60	$55	$50	$45	$40	$40	$40
$35,000 - $39,999	$65	$60	$55	$50	$45	$40	$40
$40,000 - $44,999	$70	$65	$60	$55	$50	$45	$40
$45,000 - $49,999	$75	$70	$65	$60	$55	$50	$45
$50,000 - $54,999	$80	$75	$70	$65	$60	$55	$50
$55,000 - $59,999	$85	$80	$75	$70	$65	$60	$55
$60,000 - $64,000	$90	$85	$80	$75	$70	$65	$60
$65,000 - $69,999	$95	$90	$85	$80	$75	$70	$65
$70,000 - $74,999	$100	$95	$90	$85	$80	$75	$70
$75,000 - $79,999	$105	$100	$95	$90	$85	$80	$75
$80,000 - $84,999	$110	$105	$100	$95	$90	$85	$80
$85,000 - $89,999	$115	$110	$105	$100	$95	$90	$85
$90,000 - $94,999	$120	$115	$110	$105	$100	$95	$90
$95,000 - $99,999	$125	$120	$115	$110	$105	$100	$95
$100,000 - $104,999	$130	$125	$120	$115	$110	$105	$100
$105,000 - $109,000	$135	$130	$125	$120	$115	$110	$105
$110,000 and above	$140	$135	$130	$125	$120	$115	$110

Special circumstances that may interfere with my ability to pay the fee (i.e.: financial hardship due to medical expenses): Documentation required if you are requesting a lower fee than what you qualify for under the Sliding Fee Scale Chart.

_____

_____

_____