SERVICE, PAYMENT 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. Sometimes, psychological testing may be appropriate. Information about testing services is covered in a separate form.

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 15 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.

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 or call 911.Therapists do not accept friend requests from current clients on social media to maintain our respective privacy.

Client Rights

The therapist is a provider of outpatient services at Wellspring Healing Center, LLC (WHC). In providing these services, client rights will be protected generally and specifically in the following ways:

1. Each client will be treated impartially regardless of race, religion, sex, sexual orientation, gender identity ethnicity, age or ability.

2. Each client will be treated with respect to personal dignity in the provision of all services.

3. Each client will be treated according to individual treatment needs by a competent, qualified, and experienced therapist, who will periodically review the individual treatment needs and treatment implemented.

4. Each client over seventeen years of age will have the opportunity to actively participate in the treatment planning process. Parent(s) and/or guardian(s) must agree to the treatment plan if the client is mentally impaired, developmentally disabled, or is a child or adolescent.

5. Each client will have an explanation of their individual treatment needs, treatment implementation, plans, and discharge plans, as well as any necessary aftercare plans.

6. Each client's personal privacy and confidentiality in record and verbal communication will be protected and follow WHC's procedure for information release and client consent.

7. Each client will have the right to request an alternative professional opinion in an alternate facility and may expect complete cooperation in obtaining alternative professional care subject to WHC's procedure for information release and client consent.

8. Each client will have the right to expect a full accounting of all charges for services and an explanation upon request for all charges and services rendered by WHC and/or their employees.

9. The policy of WHC's and/or their employees is to charge $60.00 for missed appointments or appointments not canceled 24 hours in advance. Each client may expect that the therapist and/or their employees will render services in compliance with the Statutes of the State of Michigan.

10. Each client has the right to refuse specific treatment procedures, however, WHC and/or their employees may, upon reasonable notice, make a referral to another appropriate facility or terminate the relationship with The client if it is felt that it is in the best interest of the client.

11.Each client has the right to initiate a complaint with WHC if they feel they have been treated wrongly or unfairly.

Consent to Treatment

The client, in contracting for outpatient psychological services with Wellspring Healing Center, LLC (WHC) and/or their employees agrees to Consent for Treatment and to acknowledge and accept the following.

1. The client gives voluntary consent for treatment and authorizes WHC's and/or their employees to administer outpatient psychological services to the client.

2. The client accepts treatment upon their own free will and may terminate treatment upon their own free will, be it verbal or written notice, and in so doing, agrees to hold WHC, and/or their employees free from any and all further responsibility to the client for the client's action.

3. The client agrees not to abuse WHCand/or their employees nor office clinic property and understands that such abuse may constitute sufficient cause for discharging the client from services with the therapist and/or employees of WHC.

4. The clinic appoints and authorizes WHC and/or their employees to demand, collect and receive all monies due and payable with any respect to insurance, medical reimbursement, benefits, disability plans, contract, or policy arising directly or indirectly out of services provided to the client or applicable family members by WHC and/or their employees and further agrees that this authorization does not constitute a waiver or release by WHCand/or their employees or any sum of money due and owing to Wellspring Healing Center, LLC and/or their employees for services provided to the client or applicable family member.

5. The client agrees to keep appointments as scheduled and to give 24-hours notice if canceling.

6. The client accepts the responsibility of paying for the treatment if the client's insurance does not cover the cost in full. The client realizes that delinquent accounts over 60 days may be turned over to a collection agency. In the event that the client's account is turned over to a collection agency, a one time 35% collection fee, as well as an annual 7% interest charge, will be added to the principal amount owed by the client to Wellspring Healing Center, LLC and/or their employees.

7. The client, in any emergency and/or life-threatening circumstance agrees to waive any previous agreement to consent to treatment and authorizes Wellspring Healing Center, LLC and/or their employees to release to any party deemed necessary to protect the life of the client or applicable family member and to hold free from all liability and responsibility for such actions Wellspring Healing Center, LLC, and/or their employees.

8. The client realizes that the therapist and/or their state-licensed employees of WHC are mandated by law to report child abuse/neglect, and abuse/neglect of other vulnerable persons (such as elderly or developmentally disabled). This reporting will be made to the appropriate social service/ law enforcement authorities and is not a breach of confidentiality as long as the reporting is done in good faith.

9. I understand my rights and responsibilities listed in this document and agree with the said policies of the practice of WHC. I understand my non-compliance with any of these policies may be cause for the closing of my case and referral to an alternative source for mental health treatment. I hereby witness the foregoing agreement and believe to the best of my knowledge at this time that the client, parent, or legal guardian, whose signature is above, is either appropriately qualified to enter into this agreement by attested identity or by mental-legal competence whereupon the party signing appears to be able to distinguish right from wrong and to understand the agreement.

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. Please note, 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 before 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.

Telehealth (video-conferencing) Services

Prior to starting video-conferencing services, we discussed and agreed to the following: There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions. Confidentiality still applies for tele-sessions, and nobody will record the session without the permission from the other person(s). We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it. You need to use a webcam or smartphone during the session. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. Please let your therapist know if the situation suddenly becomes insecure. It is important to use a secure internet connection rather than public/free Wi-Fi. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems. We need a safety plan that includes at least one emergency contact and the closest emergency department to your location, in the event of a crisis situation. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in tele-sessions. Your therapist may determine that due to certain circumstances, tele-sessions are no longer appropriate and that we should resume our sessions in-person.

How do you intend to pay for services? Your selection will take you to the next section.

○ Sliding Scale Fee

○ Please bill my insurance for me

○ I'll pay out-out-pocket and seek reimbursement myself

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.WHC reserves 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.

Consent to Treatment

I 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.

Client's Preferred Name

First Name Last Name

Client's Legal Name (if different)

First Name Last Name

Date *

Month Day Year

Third Party or Insurance Authorization

For clients choosing to have WHC bill their insurance company on their behalf

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 Responsible for account

Legal First Name Legal Last Name

Name of insurance company

Member/Enrollee ID

located on insurance card

Group

located on insurance card

Insured party

Legal Name of insured party (if NOT self)

First Name Last Name

Legal gender marker of insured party

with insurance company

Insured party's Date of Birth

Month Day Year

Address of insured party

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Informed Consent Checklist for Tele-sessions With Insurance

Prior to starting video-conferencing services, we discussed and agreed to the following: Please confirm with us and/or your insurance company that the video sessions are covered; if they are not reimbursed, you are responsible for full payment. As your therapist, I may determine that due to certain circumstances, tele-sessions are no longer appropriate and that we should resume our sessions in-person.

Legal Name

First Name Last Name

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.)

Please enter your sliding scale fee based on the above table. $

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.

Legal Name

First Name Last Name