



# MD Psychiatry & Emotional Health, PLLC

*Help. Heal. Hope.*

## FINANCIAL AGREEMENT

I acknowledge and understand that I am responsible for all charges associated with any services rendered to me or any individual for whom I am listed as the responsible party. As a courtesy, your benefits will be verified by MD Psychiatry & Emotional Health, PLLC prior to your appointment(s), however, please note that it is the responsibility of the patient to verify benefits associated with your specific health plan prior to appointments and to review the Explanation of Benefits (EOB) forms received to ensure that costs associated with your appointments are well communicated and understood. I hereby agree to pay the insurance deductible, co-payment, co-insurance or self-pay amount as services are provided. **I understand that if I do not provide my insurance information by a minimum of 48 hours prior to my initial/follow-up visit, I will be required to pay the self-pay rate at the time of service until insurance information is provided.** If for any reason there is a balance due on my account, I agree to pay promptly upon receipt of statement.

I understand that if I am filing my services rendered through insurance that my claims will be sent electronically to ReLi Med Solutions. ReLi Med Solutions will direct the insurance claim to my insurance company electronically. I understand that my insurance company will obtain information listed on the insurance claim about the diagnosis and the dates of service for psychiatric treatment sessions provided. By my signature below, and as recorded on the HIPPA consent form, I am giving MD Psychiatry & Emotional Health, PLLC permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. Furthermore, I authorize payment of my mental health benefits be made to MD Psychiatry & Emotional Health, PLLC.

Although I have requested MD Psychiatry & Emotional Health, PLLC to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. The fees for services are listed below:

### FEES FOR SERVICES (Self-Pay Rates):

- Initial Evaluation (45 min.)-\$400.00
- Med Management & Psychotherapy (20-30 min.)- \$200.00
- Med Management & Psychotherapy (45-55 min.)- \$300.00
- MM and Psychotherapy (90 min.)- \$600.00
- Consult or Professional competency (90-120 min. MD, Attorney, Engineer or Executive)- \$800.00

### CANCELLATION POLICY:

In the event that I need to cancel my appointment, I acknowledge that I must notify the office/provider **72 hours prior** to my appointment or I may be charged a no-show fee. In the event of an emergency, please contact the office and/or provider as soon as possible to reschedule.

**I have read and understand the financial agreement as detailed above. My signature represents my agreement to abide by the terms of the financial agreement, fully understand the release of information to my insurance carrier and agree to make all efforts to pay for services rendered in a timely fashion.**

Signature: \_\_\_\_\_  
(Patient or Parent/Guardian)

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_