Evolve Counseling, PLLC

P.O. Box 152
Selmer, TN 38375
(731) 610-8862

FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing Evolve Counseling, PLLC as your therapy provider. Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancellations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, please ask your provider prior to signing this Agreement and Policy. Our service rates and corresponding health insurance billing codes (numbers starting with '90' refer to mental health services) this is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

90791 Tele Mental Health Initial Consultation – Individual (50-60 min.) $200.00

90837 Tele Mental Health Individual Therapy (60 min.) $150.00

90834 Tele Mental Health Brief Individual Therapy (45 min.) $100.00

90832 Tele Mental Health Brief Individual Therapy (30 min.) $80.00

CHARGES NOT COVERED BY INSURANCE

- Medical Records Requests $25.00 per request
- Phone Consultations (11-60 min.) $130.00 (pro-rated per 15 min.)

ADDITIONAL FEES

- Late cancellations/Missed Appointment – fewer than 24 hrs. prior to appointment $25.00
- Past - due accounts – over 30 days $25.00 per month
- Checks returned due to insufficient funds will incur a fee of $45.00

PAYMENT

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You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided. Accepted methods of payment are cash, debit, HSA or credit cards.

INSURANCE REIMBURSEMENT

Evolve Counseling, PLLC accepts and process insurance payments through a variety of insurance providers and employee assistance plans. If you are using insurance or employee assistance provider to pay for our services, then we will:

- Expect and accept payment of your co-payment amount at the time of service
- File your claim with the insurance provider
- Receive payment from your insurance provider
- Expect that you will pay your portion due of co-pay, co-insurance, deductible, or fee difference at the time of your appointment.

PLEASE NOTE

Evolve Counseling, PLLC files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If your insurance company denies a claim filed on your behalf, then you are responsible to pay Evolve Counseling, PLLC for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by Evolve Counseling, PLLC

- I agree to allow Evolve Counseling, PLLC to bill my insurance directly for services provided under the Outpatient Services Agreement.
- I give Evolve Counseling, PLLC permission to release any information the insurance company may require in order to process payment; appoint Evolve Counseling, PLLC as my authorized representative to act for me in obtaining payment.
- I assign all of my rights to claims and payment by my insurance to Evolve Counseling, PLLC

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- I agree to assist with the claims process as required by Evolve Counseling, PLLC or my insurance provider.
- I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met.
- I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.
- I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Patient name (printed)

_____

Patient /Guardian signature:

_____

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Private/Self

Payment for Services

I will self - pay for services provided by Evolve Counseling, PLLC. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Patient name (printed)

_____

Patient /Guardian signature:

_____