



Patient Self-Pay Agreement

You have registered as a private pay patient. This means that at the time of service you will be paying by cash, check, or debit/credit card. Due to this cash payment, you are receiving a discount. **We will not bill insurance** for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

____ I understand that I will be responsible for all charges related to the services provided to me by Psychiatry Northwest LLC/TMS Washington

____ I understand that the charges presented to me are due **in full** on the day of service, unless arrangements have been made with the Billing Manager in advance.

SERVICE FEES:

- New Patient Evaluation: \$350.00
- 15 minutes Brief Medication Management Appointment \$150.00
- 25 minutes Expanded Medication Management /Therapy Appointment \$200.00
- 45 minutes Detailed Medication Management / Therapy Appointment \$275.00
- 60 minutes Comprehensive Medication Management / Therapy Appointment \$300.00
- Telephone / Video Appointments same as above
- Complex prior authorization or documentation completion, such as letters, forms completion requiring greater than 15 minutes of time will incur a \$50.00 fees
- Missed appointments or late cancellation, with less than 2 business days notice will incur a \$75.00 fees
- Sending Medical Records Handling Fees \$ 35.00 for first 50 pages and 10 cents for each additional page thereafter.

I have read and fully understand the above self-pay rates and I agree to waive insurance billing and pay my balance owed at the time of check-in. I also understand by signing this acknowledgment that I will be responsible to pay for the services rendered to me and/or my dependent.

Responsible Party Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____



Pre-Authorized Use of Credit/Debit Card

I, _____, authorize Harmony Mental Health Services of NW to keep my debit/credit card on file and charge for treatment services performed and to pay late cancellation or missed appointments fees.

I understand that it is my responsibility to confirm my insurance coverage and benefits prior to treatment. If my insurance applies any charges to my annual deductible or coinsurance, I understand that payment is still due and will be paid at the time the services are rendered.

I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Patient Name: _____.

Signature: _____ Date: _____



Credit/Debit Card on File

The information provided will be discarded according to HIPPA standards as soon as it has been entered into the payment system.

Patient Name

Cardholder Name

Cardholder Address

City

State

Zip

Debit/Credit Card Number

CVV

Expiration Date

Cardholder Signature

Date