HARMONY
MENTAL HEALTH
SERVICES OF NW

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 Managment / 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 then 15 minutes of time will incur a $50.00 fees
- Missed appointments or late cancellation, with less then 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: _____

1499 Tech Center Place, Suite 190, Vancouver, WA 98660
Phone: 360-828-7802 | Fax: 360-326-2606 | https://www.eliagonzalezrodriguezmd.com

HARMONY
MENTAL HEALTH
SERVICES OF NW

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: _____

1499 Tech Center Place, Suite 190, Vancouver, WA 98660
Phone: 360-828-7802 | Fax: 360-326-2606 | https://www.eliagonzalezrodriguezmd.com

HARMONY
MENTAL HEALTH
SERVICES OF NW

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

1499 Tech Center Place, Suite 190, Vancouver, WA 98660
Phone: 360-828-7802 | Fax: 360-326-2606 | https://www.eliagonzalezrodriguezmd.com