Minnesota Center for Collaborative/Therapeutic Assessment, LLC

Financial Contract

Patient Name _____ DOB _____

Street address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (Cell) _____

Please indicate preferred phone number.

Email _____

Emergency Contact _____ Phone # _____

If client is a minor, parent/caretaker name(s): _____

I am an out of network provider, but most services can be submitted for out of network reimbursement if you choose. Under the terms of this agreement, the patient or patient's legal guardian is responsible for full payment for services at the time of service.

I will provide a super bill that contains all the dates of service, billing codes and other necessary information that you can submit directly to your insurance company. Your insurance company will send any payments to you. Psychotherapy clients will receive a monthly receipt and testing clients will receive the super bill with the final document It is your responsibility to check with your insurance company about out of network coverage and whether the services rendered and billing codes on the following page will be reimbursed. I make no guarantees that you will be reimbursed any funds from your insurance. A guide for out-of-network reimbursement is available if you have not already received it.

Psychotherapy Clients

Clients engaging in psychotherapy will typically first participate in an initial Diagnostic Assessment, followed by therapy sessions, which are most often 45-50 minutes in duration. Sessions will be charged via credit card (see below) following each appointment at the rates listed.

Testing/Assessment Clients

Clients engaging in a diagnostic assessment only or traditional psychological evaluation or a Therapeutic Assessment will be quoted a flat rate after the initial session or phone call. If the final cost exceeds what is initially agreed upon, those services will be provided pro-bono. If the final amount is determined to be less that estimated, the total cost will be re-established and if necessary, funds will be refunded.

Diagnostic Assessments are one appointment, and payment is required at the end of that meeting.

Once a client agrees to participate in testing (traditional psychological evaluation or Therapeutic Assessment), the total cost will be charged in increments, unless we discuss otherwise. Should you decide to stop an evaluation once it has been started, you will be billed for the services that have been completed. This may result in an incomplete evaluation, with no formal diagnoses or recommendations provided.

For Therapeutic Assessments specifically, I expect we will have an initial meeting to establish questions for testing. For adult clients, we will then typically have 4-5 testing sessions, followed by a discussion session. For adolescents, after the initial meeting, there will typically be 5-6 testing sessions, followed by 1-2 discussion sessions. Most appointments are 90 to 120 minutes. I will send a final letter and the super bill to you approximately 4-6 weeks after our last meeting. I invite you to have a follow-up meeting with me after you receive the letter to review it and our process. This session is provided pro-bono.

Billing Codes

The following schedule summarizes my fees for service as of February 1, 2024. The number in brackets is the CPT code used by insurance companies for billing. Psychotherapy clients would only be billed the 90791 and Psychotherapy Codes. Therapeutic Assessment clients often are billed using all three types of codes. If additional time is needed for any code, billing occurs in increments of $25 per 15 minutes.

Initial Diagnostic Assessment 90 minutes (90791) $300.00

Psychotherapy Visits and Codes:

Individual Therapy 30 minutes (90832) $175.00

Individual Therapy 45 minutes (90834) $200.00

Individual Therapy 60 minutes (90837) $225.00

Family Therapy with patient present 45 minutes (90847) $200.00

Family Therapy without patient present 45 minutes (90846) $200.00

Therapy Sessions over 60 minutes are billed $25.00 for 15-minute increments

Psychological Evaluation Visits and Codes:

Test Evaluation Services 30-minute increments (96130 & 96131) $125.00

(Includes integration of data, interpreting standard test results and clinical data, clinical decision making, treatment planning and report and interactive feedback.)

Test Administration and Scoring 60-minute increments (96136 & 96137) $250.00

Late Cancel or Missed Appointments (within 24 hours of appointment) $175.00

Payment

While payment may be made at the beginning of a session with cash or checks, all clients must have a credit card on file. I use Ivy Pay (https://www.talktoivy.com/ivypay), which is a credit card payment system designed specifically for mental health providers.

Ivy Pay works with your debit card, credit card, HSA or FSA account. It is HIPAA secure, meaning it keeps our relationship confidential. You will receive a text from Ivy Pay that asks you to enter a credit card. Following the initial session and all subsequent sessions, your card will be charged through Ivy Pay. For psychotherapy clients, this means a charge after each session. For testing clients, you will typically be charged in fifths through the evaluation process.

I understand my financial responsibility and agree to have a credit card on file and pay my portion as described above. _____ (initial here)

I confirm that I have checked with my insurance company to understand what, if any, out of network benefits I may have. _____ (initial here)

I understand that there is a fee for missed appointments/late cancelations (within 24 hours of appointment); I agree to pay $175.00 for any missed appointments or late cancelations. This is uncollectible by insurance and will be my responsibility to pay. _____ (initial here)

I have read, understand, and agree to the above Financial Agreement and will make every attempt to keep my account with Minnesota Center for Collaborative/Therapeutic Assessment, LLC up-to-date, accurate, and in good standing.

_____

Signature Date

_____

Printed Name

<u>Assessment Clients Only</u>

Following an initial discussion, the price for my Diagnostic Assessment or Therapeutic Assessment or Psychological Evaluation is _____. By signing below, I agree to pay this amount in full in increments, unless I am completing a Diagnostic Assessment, in which case I agree to pay the full amount on the date of service.

The total price for assessments includes records review, interview(s), administration & scoring of relevant tests, interpretation of all results, written report, and discussion of the results. Additional services can be requested and may require an additional cost (example: attendance at meetings, extra document preparation, etc.). If these additional services are requested, a new cost estimate will be provided.

Note: The estimated cost is based on the requested service and the information initially provided by the patient/parent. If the service plan changes based on patient/parent request or additional information, a new estimate will be provided, and the patient/parent can decide whether or not they want the service.

_____

Signature Date

_____

Printed Name

Disclaimer: This Good Faith Estimate shows the costs of services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created. This estimate does not include any unknown or unexpected costs that may arise once the service begins. You will be notified if additional costs will be required. If you are billed more than the Good Faith Estimate, you have the right to dispute the bill. To do this, please contact Dr. David first (Email: raja@mnccta.com or Tel: 651-442-3038). If this is not resolved satisfactorily, you can start a dispute resolution with the U.S. Department of Health & Human Services (HHS). You must start this process within 120 calendar days of the date of the original bill. There is a $25 fee to use the HHS dispute process. If the agency agrees with you, you will pay the amount on this estimate. If the agency disagrees with you, you will pay the higher billed amount to the health care provider. To learn more or start the process, go to: www.cms.gov/nosurprises.