

Inspired Therapeutic Solutions, Inc. (ITS)

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F103 - Billing and Payment Agreement

Your fee will be set on or before your first session. **You are required to have a credit card on file as a backup form of payment for incidentals.** If you are in therapy for more than one year, there may be a small annual increase. If you receive a sliding fee discount based on your income, a deposit maybe also be required and/or a minimum amount of sessions required. You are expected to renegotiate your sliding fee discount at least every three months, or more immediately if your financial circumstances change before the three month review. Clients are expected to pay the agreed fee (and deposit when applicable) or co-pay, by DEBIT or CREDIT CARD **BEFORE**, or using **CASH ONLY AT THE BEGINNING** of each session. Telephone, video or e-mail sessions, report writing and reading, or other services requested will be billed at the same rate, unless agreed otherwise. Clients who make use of insurance or other benefits should remember that submitting claims for reimbursement *carries a risk that confidentiality may not be fully protected* and that *sometimes claims are rejected by insurance at which time you are responsible for the therapist's full fee.* Not all issues that may become the focus of psychotherapy are reimbursed by insurance companies. **It is your responsibility to verify the specifics of your coverage.** Please notify the office if a problem arises during the course of treatment regarding your ability to make timely payment. Delinquent accounts are subject to be sent to collections.

Agreed Out-Of Pocket Cost (for clients who are not using insurance)

Agreed Upon Minimum Sessions

Agreed upon fee (as of _____ n/a _____ (date).

Agreed Upon Deposit

**Deposits are due on or before the first session in addition to the first session fee. Deposits are used for sessions cancelled without 24 hour notice, for last session, or if agreed upon sessions are not honored. Deposit balance must always be maintained; therefore if deposit is used for late cancellation then new deposit is required upon next visit.*

Insured Costs (for clients using insurance coverages) **(Please fill out the approved amount of Sessions from EAP)**

ComPsych Total Sessions

Health Advocate Sessions

Anthem Sessions

Co-Pay Amount \$ verified by _____ as of _____ (date)

Insured Costs (for clients using insurance coverages (insurance carrier).

If your insurance carrier rejects a claims for any reason, than you are responsible for the full fee amount of \$. The balance owed would be (insurance carrier portion) in addition to the \$ (client co-pay). The full fee amount of \$ is also due if appointments are not cancelled within 24hrs as Insurance Carriers do not pay any portions for missed or cancelled appointments. The range of price is inclusive of multiple types of session; crisis, individual, family, couple, etc.

Debit / Credit Card Information

Name as it appears on Credit/Debit Card _____

Credit Card Billing Address _____

City _____ State _____ Zip _____

Email _____

(if you prefer to pay online or receive invoices or receipts electronically)

_____ Exp. Date _____ CVV _____

Card Number

(3 digits on back of card)

I HAVE READ THE ABOVE POLICIES AND PAYMENT AGREEMENT CAREFULLY. I UNDERSTAND THEM AND AGREE TO COMPLY WITH THEM.

Client name (print) _____

Date _____

Signature _____

Payment is expected at the time of each visit, unless otherwise arranged in advance. 24-hour notice is required for cancellation or change of hour; otherwise the session will be billed at the full fee rate. The listed credit card will be billed for missed appointments, bounced checks, and insurance claim denials. Two no-show/unexcused appointments may result in termination. No exceptions are made.