MARRIAGE & FAMILY SOLUTIONS, LLC

Consent for Payment

As a courtesy to you, Marriage & Family Solutions, LLC will prepare claims and submit them to your insurance provider or HMO. If your insurance provider rejects the claim or does not pay the full cost, you are personally responsible to pay any remaining balance on your account. It is important you pay your balances promptly to avoid any potential disruption to your medical services.

1) I consent to be named as guarantor on this account and will be directly responsible to Marriage & Family Solutions, LCC for charges incurred.

2) I authorize payment of medical benefits directly related to Marriage & Family Solutions, LLC for services provided. If my insurance company pays me directly, I will be responsible for providing the clinic with payment and a copy of my explanation of benefits (EOB).

3) I understand, as guarantor that I am responsible for all co-payments or co-insurances for services on this account.

4) I understand that fees may be assessed for any appointment that is missed or not canceled at least 24 hours in advance. *(Please note many private and public insurance companies such as: Medical Assistance, HMO plans, or other service underwriters will not pay for last minute cancelations or missed appointments and that I will likely be responsible for fees assessed)*

5) I understand that my failure or inability to pay for services at the time payment is due will likely result in my dismissal from Marriage & Family Solutions, LLC.

6) The estimated fees for services are listed below. Payment is due at the time services are rendered.

PSYCHOTHERAPY DELAYED PAYMENT	**CPT CODE**	**FEES**
Psychotherapy (60 minutes)	90837	$135.00
Psychotherapy (45 minutes)	90834	$101.25
Psychotherapy (30 minutes)	90833	$67.50
PSYCHOTHERAPY PROMPT PAYMENT (DAY OF)	**CPT CODE**	**FEES**
Partner Level (post-license)	90837	$110.00
Masters Level (post-graduation)	90837	$75.00
Intern Level (completing master’s program)	90837	$40.00

Please note, if your therapist advances during your treatment time you can pay the higher rates or transition to a therapist at your current level.

I acknowledge that I understand the above and give my informed consent to be evaluated for medication management services by a prescriber.

Patient Print Name

Patient Signature *(or Personal Representative's Signature)*

Date

If signed by a Personal Representative: *(If the individual has a personal presentative with legal authority to make health care decisions on the individual's behalf, the notice must be given to, and acknowledgment obtained from the personal representative.)*

Print Name: ______________________ Role: ______________________
(Parent, legal guardian, etc.)

STAFF INITIALS