CONSENT FOR TREATMENT AND FINANCIAL POLICY

Prism Reflections, LLC/Anew Psychiatry, LLC
1-803-201-3078 (p), 1-803-678-4260 (f)

Client Name_____

Thank you for choosing us as your Mental Health Providers. We are committed to providing the best possible care. Our goal is that you and/or your child's treatment will be successful. Please understand that payment is considered a part of you and/or your child's treatment. Please read the following Consent for Treatment Policy Statement and sign below.

Financial Obligations 1) Full payment is required at the time of service. If you have health insurance it should be understood that this is a contract between you and your insurance company. Your Provider's bill is an agreement between you and your Provider.

* Psychiatric evaluation appointments (45-60 minutes) are billed at $250.00-$300
* Psychotherapy appointments (45-60 minutes) are billed at $100-150.00
* Medication Management follow-up appointments (up to 30 minutes) are billed at $125-$150.00
* Other appointments/services are pro-rated and billed based on this fee schedule
*Completion of paperwork such as disability forms are billed at $50 per packet.

Your Rights as a Patient :

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the Department of Regulatory Agencies.

You, as a client, are entitled to receive information about the methods of therapy, and medication management, the duration of the therapy/medication management (if known) and the fee structure. You may seek a second opinion from another provider or may terminate your treatment at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the grievance board immediately.

The information provided by you during any of your sessions is legally confidential; except for certain legal exceptions which will be identified by the licensee should any such situation arise during treatment.

1)Select insurance companies will be accepted for payment. Prism Reflections, LLC will make every effort to verify benefits before your first appointment, although it is your ultimate responsibility to assure your insurance will cover your appointments. Should your insurance deny payment at the time of billing, it is your responsibility to pay for your appointment in a timely manner.

2) Cash or credit cards are accepted for payment. All accounts more than 60 days past due will accrue interest at a rate of 18% annually, pro-rated on a monthly basis. These accounts may be turned over to a collection agency. No further appointments or medication refills are given until such accounts are fully paid.

3) Master Card, Discover, select HSA cards and Visa are accepted. Please list the credit card type you wish to use, with the number and expiration date, VIN number (the last three numbers on the back of your card in the signature box), and zip code (the VIN number and zip code ensure security):

Card Type: VISA MC DISCOVER OTHER_____
Card Number:_____

Expiration (month/year):

Vin Number (3 digit code on back)

Zip Code:

4) Unless cancelled at least 24 hours in advance, you will be charged the full fee for missed appointments. You will be responsible for settling that charge before your next appointment.

5) We currently accept a select few insurance plans. However, we will provide a receipt and additional documentation (if requested) to facilitate submitting claims. Please be aware that you are responsible for all charges for professional services rendered on behalf of the identified patient, including any charges not reimbursed by your insurance carrier. Note that some of the services may not be covered by your insurance such as services provided outside of scheduled appointment times, including phone calls, letters, reports, faxes, copying of records, or consultations with other providers, schools, or insurance companies.

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I have read the Financial Policy. I understand and agree to the terms of the Financial Policy. I understand that I am responsible for services provided and for any collection of attorney fees, or court costs associated with use of outside agencies required for collection fees.

I consent to the use or disclosure of my protected health information by Prism Reflections, LLC providers for the purpose of diagnosing or providing treatment, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment by Prism Reflections, LLC provider's may be conditioned upon my consent as evidenced by my signing this document.

I have read the Consent for Treatment Policy. I understand and agree to the terms of the policy. I understand that I am responsible for services provided and for any collection of attorney fees, or court costs associated with use of outside agencies required for collection.

Client_____Date_____

Provider_____Date_____