Self-Pay Agreement: Reduced Rate

Client's Name: ____ Client's Date of Birth:__________________

Treatment start date (date of the client's first scheduled appointment): ___________________________________

This Self-Pay Agreement is intended to provide clients, parents/legal guardians, and/or financially responsible parties with an understanding of their financial responsibilities should they elect to self-pay for services. It also aims to provide information on whether the client qualifies for reduced rates and the amounts for the reduced fee schedule.

General Guidelines for Reduced Rates Payments:

Please select the total annual gross income earned by all employed members of your household. Children and other dependents would be included in the total number of household members. Amounts are based on the 2023 Federal Poverty Levels (www.healthcare.gov).

[ ] For Individuals - $14,580

[ ] For a family of 2 - $19,720

[ ] For a family of 3 - $24,860

[ ] For a family of 4 - $30,000

[ ] For a family of 5 - $35,140

[ ] For a family of 6 - $40,280

[ ] For a family of 7 - $45,420

[ ] For a family of 8 - $50,560

[ ] For a family of 9 or more - Additional $5,140 for each extra person

If your income is at or below the poverty level indicated above, you may be eligible for a Reduced Rate. Please note the posted fees are guidelines and may be adjusted based on your income, expenses, and ability to pay.

I understand and agree that:

1. The client is not currently enrolled in or eligible for Medicare, Tricare, or Medicaid.
2. The client is not seeking treatment from Art of the Heart Counseling Services for a work-related injury or for assistance with disability paperwork.
3. The client/financially responsible party elects to self-pay for all services received from Art of the Heart Counseling Services.

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I also represent that (select which applies to you/the client):

[ ] The client has health insurance coverage; however, Art of the Heart Counseling Services does not currently accept the client's health insurance plan.

[ ] Art of the Heart Counseling Services accepts the client's health insurance plan which may cover some or all of the services rendered to the client, however I have instructed Art of the Heart Counseling Services not to submit claims to the client's health insurance plan and agree to forego the ability to submit claims to the client's health insurance plan directly for services rendered to the client.

[ ] The client does not currently have health insurance coverage.

By signing this agreement, I certify that the client does not have health insurance or certify that the client will not/cannot utilize any health insurance for services rendered by Art of the Heart Counseling Services LLC, and due to my/the client's financial situation, I/the client cannot afford the full fee therapy rates. I, the financially responsible person, therefore, request that my/the client's fee be adjusted. Based on the Federal Poverty Guidelines, my current monthly personal and/or household income is currently insufficient to cover my monthly expenses and the full fee therapy rates. Therefore, I understand that the reduced fee for services with Art of the Heart Counseling Services LLC are as outlined below, and that the fee is payable at the time of each session.

90791: Psychiatric Diagnostic Assessment, 90 mins - $110
90834: Psychotherapy, 45 mins - $75/session
90837: Psychotherapy, 60 mins - $90/session
90846: Family Psychotherapy without the client present - $75/session
90847: Family Psychotherapy with the client present - $75/session

I further understand that I/the client will not be charged for any appointments that are cancelled at least 24 hours in advance. I understand that appointments not cancelled at least 24 hours in advance are subject to a "Late Cancellation" or "No Show" charge. I understand that I am solely responsible for all these charges as well as the costs associated with collecting these charges.

I agree to notify Art of the Heart Counseling Services LLC of any substantive changes in my financial situation (e.g., 10% increase or decrease in income) within 30 days of the change and understand the fee may change according to my updated financial situation. I further acknowledge that my therapist will periodically verbally review my financial status with me to reassess eligibility. A continuance of Reduced Rate benefits is not guaranteed and is subject to modification and/or elimination at the sole discretion of Art of the Heart Counseling Services LLC.

Should I or my child become a self-pay patient:

1. I agree to pay Art of the Heart Counseling Services for services rendered at the time of my visit.
2. I agree to provide Art of the Heart Counseling Services with a valid credit card to be kept on file and authorize Art of the Heart Counseling Services to charge my credit card for services rendered at the time of service.
3. I agree to notify Art of the Heart Services in writing if I no longer wish to self-pay for services and provide Art of the Heart Counseling Services with third-party payment information as appropriate. This change in financial information will become effective upon receipt by Art of the Heart Counseling Services and will not apply to services rendered to me prior to that date.

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4. I understand that in signing this I waive any future right to be reimbursed by my insurance plan for services that have already been provided unless I sign a separate written agreement with my provider indicating any changes.

5. I understand that this agreement is subject to revocation at any time except to the extent that action has been already taken in reliance thereon.
6. I understand that I have a right to a copy of this form.

By signing this agreement, I certify that I am the person financially responsible for services rendered to me/my child/the client, and that I have read and agree to be bound by this Self-Pay Agreement.

Financially Responsible Person Completing this Form: ____

Signature: ____

Relationship to Client: _______________________________

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