PSYCHIATRY NORTHWEST

Patient Self-Pay Agreement

You have registered as a private pay patient. This means that at the time of service you will be paying by cash, check, or debit/credit card. Due to this cash payment, you are receiving a discount. **We will not bill insurance** for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

____ I understand that I will be responsible for all charges related to the services provided to me by Psychiatry Northwest LLC/TMS Washington

____ I understand that the charges presented to me are due **in full** on the day of service, unless arrangements have been made with the Billing Manager in advance.

Self-Pay Rates:

Physician Appointments

New Patient Evaluation: $350

Follow-Up Appointments: $150

Phone Follow-Up Appointments: $125

Psychotherapist and Mental Health Counselors

New Patient Evaluation: $175

Follow-Up Appointments: $150

PA-C and ARNP Appointments

New Patient Evaluation: $250

Follow-Up Appointments: $ 100

QB Test (ADHD Diagnostic Exam): $150

Transcranial Magnetic Stimulation (TMS) Treatment

Brainsway: $4,999

Magpro: $2,999

I have read and fully understand the above self-pay rates and I agree to waive insurance billing and pay my balance owed at the time of check-in. I also understand by signing this acknowledgement that I will be responsible to pay for the services rendered to me and/or my dependent.

Responsible Party Name: _____ Relationship to Patient:_____

Signature: _____ Date: _____

2150 N. 107th St. Ste 460 Seattle, WA 98133
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Payment Plan

Patient Name: _____ Date: _____

Balance: _____

The above-named patient (or guarantor) agrees to make monthly payments on the past due balance of this account. Payments will be made on or before the _____ day of each month. **The minimum monthly payment for balances $500 or less is $75 a month.** Failure to meet this obligation will make the agreement null and void and the practice will then reserve the right to make a "Demand for Payment" in full, on the remaining balance. Balances greater than $500 require a down payment and the monthly payment to be agreed upon with the Billing Manager.

While on a payment plan, I am required to pay the current visit's copay, deductible, or coinsurance at the time of service in addition to the agreed monthly payment.

Minimum monthly payment agreed upon: $_____

ALL OTHER CHARGES WILL BE PAID AT THE TIME OF SERVICE (co-pay, co-insurance, self-pay, deductible).

_____	_____	_____
Patient/Guarantor Name	Signature	Date

_____	_____	_____
Authorized Employee Name	Signature	Date

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Pre-Authorized Use of Credit/Debit Card

I, _____, authorize Psychiatry Northwest to keep my debit/credit card on file and charge for **TMS copays or co-insurance balances** on the Friday of each week according to the number of treatments done.

As a courtesy, Psychiatry Northwest will submit a claim to your insurance company. Prior authorization has been confirmed prior to beginning TMS treatments, and all TMS visits are considered "outpatient mental health services in an office setting" under your benefits.

I understand that it is my responsibility to confirm my insurance coverage and benefits prior to treatment. If my insurance applies any charges to my annual deductible or coinsurance, I understand that payment is still due and will be paid on the Friday of each week, or unless otherwise agreed upon by the billing team, on a case by case basis.

I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

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Credit/Debit Card on File

The information provided will be discarded according to HIPPA standards as soon as it has been entered into the payment system.

_____

Patient Name

_____

Cardholder Name

_____

Cardholder Address

_____

City State Zip

_____

Debit/Credit Card Number CVV Expiration Date

_____

Cardholder Signature Date

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