Financial Agreement

I understand that I am financially responsible for the Ken Starr MD Wellness Group outpatient services defined in this agreement*. I attest that I have been informed of the importance of not being under the influence of any alcohol or drugs while agreeing to treatment. I understand that while Ken Starr MD Wellness Group staff consistently assesses my comprehension and competency to agree to services and fees, they cannot provide an absolute guarantee of competency. For this reason, it is critical that I am honest and forthcoming with staff as to whether my services should be rescheduled due to my inability to comprehend. ***Less than 24 hour cancellation: Patient will be charged the missed appointment fee <u>prior</u> to scheduling a future service.**

PAYMENT & REFUND POLICY

I understand that as a Ken Starr MD Wellness Group patient, I am required to maintain an active credit card on file. I understand that my credit card will be used for appointment and service fees due to late cancellation and/or no-shows. If I am paying with cash only and not billing insurance, I understand that fees are due prior to the delivery of services. If I am paying with a package rate, payments will need to remain current in order to continue receiving seamless services. I understand that I must attend services within the time frame/package I have agreed to. I understand that fees are not negotiable and that failure to pay may result in discontinuation of services with a referral. Similarly, I understand that I will not be eligible to receive letters or reports of treatment compliance or completion without a paid in full balance. I understand that I am responsible for payment for all services rendered and will inform my therapist or staff member when I am unable to continue paying for treatment in order to discuss alternative payment options. I understand that there is no refund for services once services have begun and are honored by Ken Starr MD Wellness Group. I also understand that I will not be provided a refund for services if I arrive for such services in a violent, agitated, intoxicated or otherwise under the influence state. If I have paid for services that I cannot attend/receive due to my own personal circumstances, I will not be entitled to a cash refund but I will be allowed to credit this payment toward future services (does not apply to program packages). All credits will expire 6 months from the original date of purchase. If I did not receive services due to the inability of the practice to provide, I will be entitled to a credit or cash refund. **These and all** refunds may be subject to a 15% processing fee. Credit card refunds will be subject to a 4% processing fee. Ken Starr Wellness Group may provide superbills to patients for services rendered. Superbills are to be submitted for reimbursement to private insurance only. They may not be submitted to Medical/Medicare.

INSURANCE COVERAGE

The Ken Starr MD Wellness Group is currently contracted for certain services through Anthem Blue Cross and Blue Shield plans serviced by Magellan. I understand that I am responsible for payment of all deductibles, co-payments,

and co-insurance amounts as outlined in my plan. If my insurance policy requires ‘prior authorization’ in order to receive services, I understand that Ken Starr MD Wellness Group and its affiliates will act in good faith on my behalf to request prior and continued authorization for services as clinically appropriate.

I understand that Ken Starr MD Wellness Group is out of network for all other insurances at this time. As a courtesy per request, and with a signed release of information, they will attempt to get authorization for payment and bill my insurance for services rendered. I understand I am ultimately responsible for payment for all services rendered by Ken Starr MD Wellness Group, as insurance reimbursement cannot be guaranteed. If my insurance does not cover all or part of my care, I may request a ‘superbill’ to advocate directly to my insurance for payment reimbursement. If my insurance policy requires ‘prior authorization’ in order to receive services, an office staff will assist me in acquiring pre-authorization with the understanding that Ken Starr MD Wellness Group will not be held liable for future insurance claims of reimbursement. I understand I will receive a billing statement from Ken Starr MD Wellness Group reflecting any balance due on my account. I understand Ken Starr MD Wellness Group will not accept responsibility for collecting insurance claims or negotiating a settlement on a disputed claim. I understand that failure to pay Ken Starr MD Wellness Group may jeopardize my insurance benefits and ability to receive services. I understand that since I am the individual receiving services, I am financially liable. I acknowledge that fees within my Financial Agreement reflect cash rates billed to the patient; they may not reflect the true and actual cost of service reflective of industry standards and customary fees. I understand that the cost of insurance copays may exceed the cash price discount I pay; in such an event I will complete a financial waiver to resolve the difference. I understand that there is a 15% fee for handling and distributing insurance reimbursement payments. Reimbursement after insurance, if any, will be based upon the allowable amount listed on the Explanation of Benefits. I may choose to accept a ‘superbill’ and bill my insurance directly in order to avoid such fees; in this event I would be a ‘cash pay’ only client.

DELINQUENCY

I understand that Ken Starr MD Wellness Group will make several attempts to collect payment. I will be notified by telephone and letter once my account becomes delinquent after 30 days. I understand that if my account is more than 90 days in arrears and no attempt has been made on my part to return calls or set up a payment plan, my account will be terminated and sent to a collection agency.   I understand that a re-billing fee of 5% in compliance with California state law will be applied to any overdue balance. In the event of non-payment, my bill will be subject to collections with an additional 20% fee in addition to court costs and reasonable legal fees.

LATE CANCELLATIONS

I understand that I must call to cancel an appointment 24 hours or more in advance, otherwise I must pay the appointment fee I missed in order to schedule future appointments. If I have paid for a program package, a less than

24 hour cancellation will result in the service appointment being counted as 'used'. I will not be allowed to recover a missed appointment if I did not follow the 24 hour cancellation requirement. I understand that if my credit card is on file, it will be used for payment of services scheduled that do not receive a 24 hour or more cancellation. I understand that my insurance policy will not cover the missed appointment fee.

FEE SCHEDULE - Cash Price - Insurance costs will differ depending upon deductible, copay and coinsurance

New Patient Medical Assessment ------------------- $295
New Patient Med. Assess - Telehealth---------------$495
New Patient Clinical Assessment ------------------- $250

Established Patient Medical Follow Up ----------- $145
Prescription Call In ------------------------------------ $30
Drug and Alcohol Testing ---------------------------- $45
Court Admissible Testing ----------------------------$195
Vivitrol/Sublocade Administration -----------------$145
Spravato/Esketamine Administration ----------------$80

Individual Counseling Session ----------------------$130
Family / Couples Session ----------------------------$160
Outpatient (OP) Group Session 1.5 hrs.-------------$50
Intensive OP Group Session 3 hrs. -------------------$70

SAP Evaluation ---------------------------------------$795

Reports / Letters --$30
Verification of Benefits --------------------------------$30

Medically Supervised Detox (per day)--------------$850
NAD Detox (per day)--------------------------------$1300
IOP (per week) --$355
IOP monthly package --------------------------------$1420

I have read and fully understand Ken Starr MD Wellness Group's Financial Agreement. I am agreeing to the policy that has been thoroughly explained to me, with opportunity for questions and answers. All questions or concerns have been answered to my satisfaction. I have been provided with a copy of the following Admission Agreement.

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Client Signature Date

____

Client Printed Name Date

____

SIGNATURE of Person with Financial Responsibility (if other than patient) Date

Printed Name of Person with Financial Responsibility: ___________________________________

Phone Number ____

Address ____

Ken Starr MD Wellness Group
107 Nelson St, Arroyo Grande CA 93420
Ph: (805) 242-1360 Fax: (805) 528-8178

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