Professional ASSOCIATES
LINDNER CENTER OF HOPE

FINANCIAL RESPONSIBILITY AGREEMENT
TELEPHONE VISITS SELF PAY SERVICES

Patient Name: _____ **MR#** _____ **Date:** _____

Financially Responsible Party: _____
(if other than Patient)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT FOR SERVICES NOT COVERED BY INSURANCE:
Lindner Center of Hope Professional Associates (LCOHPA) appreciates the confidence you have shown in choosing us to provide health care services to you or a patient for whom you have responsibility. Our patient and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies.

I acknowledge that I am financially responsible for all charges associated with health care services provided by LCOHPA to me (or the patient named below) related to telephone visits. I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance. I understand this service is completely self/private pay and is unbillable to my insurance coverage. As such an itemized statement is not available.

The charges listed below are not a full listing of charges but represent the most utilized by provider type. The discount for clinician services calculated under the AGB guidelines is 42% for patients that reside in Ohio. For patients residing outside Ohio the self-pay discount is 25%. Such discount will show up on our patient statement as applicable.

Audio Only Visits

CPT Code	Description	Psuedo Code	MD Price	Non-MD Price
99212	LCOH Audio Established Patient E/M Service Straightforward	LCHAEM212	$110	$99
99213	LCOH Audio Established Patient E/M Service Low	LCHAEM213	$175	$158
99214	LCOH Audio Established Patient E/M Service Moderate	LCHAEM214	$245	$221
99215	LCOH Audio Established Patient E/M Service High	LCHAEM215	$345	$311
90833	LCOH AUDIO PSYTX W/PT W/EM 30 MIN	LCHAETX30	$135	$122
90836	LCOH AUDIO PSYTX W/PT W/EM 45 MIN	LCHAETX45	$175	$158
90838	LCOH AUDIO PSYTX W/PT W/EM 60 MIN	LCHAETX60	$210	$189
90832	LCOH AUDIO PSYTX W/TX 30 MINUTES	LCHAUTX30	$145	$131
90834	LCOH AUDIO PSYTX W PT 45 MINUTES	LCHAUTX45	$200	$180
90837	LCOH AUDIO PSYTX W PT 60 MINUTES	LCHAUTX60	$280	$252
90846	LCOH AUDIO FAMILY PSYTX W/O PT 50 MIN	LCHFAWOPT	$205	$185
90847	LCOH AUDIO FAMILY PSYTX W/PT 50 MIN	LCHFAWTPT	$215	$194

Other Services: _____

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE.
I am the patient or am legally authorized to sign this document. I have read and understand this Consent for Self-Pay Services.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian

_____
Relationship of Legal Guardian to Patient

_____ _____
Signature of Financially Responsible Party Date

_____ _____
LCOHPA Witness Signature Witness Date/Time