LINDNER
CENTER OF HOPE

4075 Old Western Row Road
Mason, Ohio 45040
(513)536-0537 or 1(888)537-4229

RAPID ACCESS SERVICE CONTRACT

Lindner Center of Hope (The Center) appreciates the confidence you have shown in choosing us as your treatment care provider. 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 this agreement prior to signing.

Given the nature of the program and that it is not separately billable to insurance we are unable to provide an itemized statement for services rendered.

PAYMENT RESPONSIBILITY:

I acknowledge that I am financially responsible for all charges associated with services provided to the patient named be low through the Rapid Access Service. I understand that the deposit payment outlined below is due at the time of scheduling admission into the program and full payment of remaining balance is due prior to the start of services the day of admission.

I understand this program is completely self/private pay and unbillable to my insurance carrier.

RAPID ACCESS SERVICE PROGRAM PRICING:

Initial Appointment

Program Deposit to schedule appointment (NON-REFUNDABLE) $100

Start Date _____ End Date _____

Balance of program due at the time of admission $525

Total program cost **$625**

Date of deposit: _____

Bridge Appointment:

Program Price per visit: $300
Up to three appointments may be scheduled at a mutually exclusive time for psychiatrist and patient.

SERVICES INCLUDED IN PROGRAM PRICING

- 2.5 hour average visit
- 40 to 60 minute visit with social worker
- 30 minute screening completion
- 45 to 60 minute meeting with psychiatrist or APRN
- Presentation of plan of care with recommendations
- Psychological evaluation and testing

I fully understand and agree to the above policies and conditions described in this agreement.

Patient's Signature: _____ Date: _____

Person Financially Responsible Name: _____ Signature: _____
(please print)

Address: _____ Date: _____

LCOH Staff Signature/Title: _____ Date/Time: _____