

**MAJOR DEPRESSIVE DISORDER WITH TMS ADMISSION AND EXTENSION**

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.

**PAYMENT RESPONSIBILITY:**

I acknowledge that I am financially responsible for all charges associated with services provided to the patient named below through the Major Depressive Disorder with TMS program. I understand that payment outlined below is due in full prior to admission to the Major Depressive Disorder with TMS program and full payment prior to the start of additional services. I understand that interruption of a program for a clinically determined medical condition will result in suspension of the program until such time as the patient is cleared to complete the program. Any medically determined inpatient stay is separately billable to insurance and the financially responsible party is responsible for any co-pay and deductibles under their plan. If insurance does not cover the inpatient stay the financially responsible party is responsible for payment at the self pay rate. Patient will be entitled to any remaining prepaid days of treatment. **For patients requiring additional staff due to higher levels of acuity or risk will be charged an additional daily fee of \$600.00.** Payment for the additional days must be received prior to the end of the original contract term. At my request, The Center will inform me of their ability to assist me in billing my insurance but will not be responsible for appeal and follow-up on claims. **I acknowledge the Major Depressive Disorder with TMS services are an elective self-pay treatment program. I understand I am financially responsible for the payment of these services.**

**Major Depressive Disorder with TMS ADMISSION AND EXTENSION SELF PAY PROGRAM PRICING:**

(Indicate program patient is entering)

<input type="checkbox"/>	Initial Treatment (no CDA) (7 weeks, 49 days)		\$105,000
		Suite	\$107,000
	Start Date _____	End Date _____	
	Tentative Discharge Date _____		
<input type="checkbox"/>	Treatment Extension (7 weeks, 49 days)		\$96,400
		Suite	\$98,400
	Start Date _____	End Date _____	
	Tentative Discharge Date _____		
<input type="checkbox"/>	Weekly Rate (7 day)		\$13,500
		Suite	\$15,500
	Start Date _____	End Date _____	
	Tentative Discharge Date _____		
<input type="checkbox"/>	Daily Rate	\$1,925 x _____ = _____	
	(for day to day extensions)		
		Suite \$2,025 x _____ = _____	
	Start Date _____	End Date _____	
	Tentative Discharge Date _____		
<input type="checkbox"/>	TMS (36 Sessions if not covered by insurance)		\$14,500
	Start Date _____	End Date _____	
	Tentative Discharge Date _____		

**SERVICES INCLUDED IN PROGRAM PRICING**

Room and Board  
Personal Care Services  
Residential Services  
Individual Psychotherapy  
Group Therapy  
Pharmacy (Formulary)  
Nutritional services  
Spiritual Care services as desired  
Physician Services  
Laboratory Services  
Minimal 2 staff members on unit at all times with accessibility to a nurse at all times

**SERVICES INCLUDED IF CLINICALLY INDICATED by LCOH Treatment Team**

Brain Magnetic Resonance Imaging (MRI)\*\*  
Electroencephalography (EEG)\*\*  
\*\*Not included in Transitional Week Services

**ADDITIONAL FEES BILLED SEPARATELY FOR:**

External Consults (including ER visits)  
Electroconvulsive Therapy (ECT)  
Transcranial Magnetic Stimulation (TMS)  
Esketamine Treatment  
GeneSightRX  
Non-formulary medications  
Case Management Service

**REFUND POLICY:**

All services and program fees are non-refundable.

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: \_\_\_\_\_