Lindner Center of HOPE | UC Health

4075 Old Western Row Road
Mason, Ohio 45040
(513)536-0537 or 1(888)53-SIBCY (7-4229)
www. sibcyhouse.org

WILLIAMS HOUSE 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.

PAYMENT RESPONSIBILITY:

I, the undersigned, acknowledge that I am financially responsible for all charges associated with services provided to the patient named below through the Williams House program. I understand that payment outlined below is due in full prior to admission to the Williams House 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. Patient will be entitled to any remaining prepaid days of treatment. If the medical condition requires detoxification on the unit during the Comprehensive Diagnostic Assessment program, additional days will be charged or testing will be completed to the extent possible within the 14 days. ***For the youth requiring additional staff (one to one) due to higher levels of acuity or risk will be charged an additional daily fee of $400.00***. 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. Furthermore, I acknowledge that Williams House services are not in-network services for any insurance plan regardless of whether Lindner Center of HOPE is an in-network provider. Any refunds due as a result of insurance reimbursement will not exceed the amount paid per the contract.

WILLIAMS HOUSE PRICING: (Indicate program patient is entering)

☐ Comprehensive Diagnostic Assessment and Treatment Program (up to 28 days) $30,000

Start Date _____ End Date _____ Option (1)

☐ Comprehensive Diagnostic Assessment (up to 14 days) (non refundable) $16,000

Start Date _____ End Date _____ Option (2)

☐ OCD Treatment Program (Initial treatment package, if Treatment Team approves admission without initial comprehensive diagnostic assessment.) (up to 14 days) (non refundable) $16,000

Start Date _____ End Date _____ Option (3)

☐ Seven Day Transitional Treatment Weeks $7,000

Start Date _____ End Date _____ Option (4)

☐ Other (determined by treatment team for extending service) $_____

Start Date _____ End Date _____ Option (5)

☐ Additional Daily Staff Fee $_____

Start Date _____ End Date _____ Option (6)

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
Psychological Testing**
Laboratory Services
Family Therapy
Educational Assessment/Support

SERVICES INCLUDED IF CLINICALLY INDICATED by LCOH Treatment Team

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

ADDITIONAL FEES BILLED SEPARATELY FOR:

Sleep Studies
External Consults (including ER visits)
Electroconvulsive Therapy (ECT)
Transcranial Magnectic Stimulation (TMS)
Non-formulary medications
Life Skill Coaching
Case Management Service/Employee Service
GeneSightRX

REFUND POLICY:

1. Refunds are only available at the weekly Transitional Rate for full weeks only. Unused days for full treatment weeks are not refundable nor can be used as credits to be applied to future programs.
2. Refunds are not available for the 14 day Comprehensive Diagnostic Assessment portion of the program.
3. Refunds are not available for days during which a patient is granted a therapeutic leave of absence.

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

Patient's Name: _____

Parent/Guardian Signature: _____ Date/Time: _____

Person Financially Responsible Signature: _____ Date/Time: _____

Person Financially Responsible Print Name and Address: _____

_____

Witness/Credential Signature: _____ Date/Time: _____