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

CHILD & ADOLESCENT ASSESSMENT PROGRAM 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 below through the Child and Adolescent Outpatient Assessment Program. 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.

CHILD & ADOLESCENT OUTPATIENT ASSESSMENT PROGRAM PRICING:

Program Deposit to schedule appointment	$2,500
Start Date _______________ End Date _______________	
Balance of program due at the time of admission	$4,300
Total program cost	**$6,800**

Date of deposit: _________________

REFUND POLICY:

1. Refunds of deposit are only available if appointment is cancelled 30 days or more before scheduled appointment date.
2. If patient needs to reschedule once deposit has been made, deposit will be credited to appointment if it is rescheduled within 90 days of original appointment.
3. Deposit is non-refundable if appointment is cancelled within 29 days or less of scheduled appointment date.

SERVICES INCLUDED IN PROGRAM PRICING

- Comprehensive psychiatric assessment performed by skilled multidisciplinary team
- Preadmission screening and evaluation of records*
- Care coordination, psychosocial assessment
- Psychiatric consultation
- Psychological evaluation and testing
- Specialty diagnostic and therapeutic consultations (as clinically indicated)
- Strengths-Based Family Assessment
- Genetic profile test with results review
- Feedback Session with diagnostic team
- Written report of results and recommendations

*Parents/guardians are responsible for obtaining requested laboratory studies through their PCP prior to admission and have results sent to LCOH or bring results with them at the time of admission. This should be done using insurance coverage.

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: ________________