Lindner Center of HOPE | UC Health

FINANCIAL RESPONSIBILITY AGREEMENT
SELF PAY or NON-APPROVED HOSPITAL SERVICES

Patient Name: _____ MR# _____ Date: _____

The Lindner Center of HOPE (LCOH) 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.

In the event that my insurance will not cover the services provided or if I choose not to use insurance, I acknowledge that I am financially responsible for all charges associated with health care services provided by LCOH to me (or the patient named above). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance. Professional fees are billed separately.

INPATIENT SERVICES: **Initials** _____

I acknowledge that I am financially responsible for all charges associated with health care services provided by LCOH to me (or the patient named above). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance. I understand that I will be responsible for the total billed hospital charges less a discount based on amounts generally billed to insurance and Medicare (discount is currently 54% of billed charges for patients residing in Ohio and 25% for non-Ohio residents). I understand that I am responsible for payment and agree to set up payment arrangements with the financial counselor prior to discharge for any balance due.

_____ I acknowledge that I (or the patient named above) do not have health insurance coverage. I understand that LCOH will extend financial assistance to uninsured or underinsured patients for inpatient services who meet certain criteria. The financial counselors can assist with this process. **OR**

_____ I request that whether or not I (or the patient named above) have insurance that may provide coverage for mental health services, LCOH may not bill my insurance company for privacy reasons. I understand that LCOH will extend financial assistance to uninsured or underinsured patients for inpatient services who meet certain criteria and that this assistance will not be considered for patients who have opted not to use active/eligible insurance or government program coverage.

OUTPATIENT HOSPITAL SERVICES: **Initials** _____

In the event that my insurance will not cover the services below or if I choose not to use insurance, I acknowledge that I am financially responsible for all charges associated with health care services provided by LCOH to me (or the patient named above). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance. Self Pay discounts are factored into the prices listed below and there will be no additional discount on the bundled rates disclosed below.

Intensive Outpatient Treatment (IOP):
$350 Per Day

Intensive Outpatient Treatment (IOP) Eating Disorders:
$375 Per Day

Transcranial Magnetic Stimulation (TMS):
$325 Per individual Session -or- $3,250 for a series of 10 TMS sessions

Electroconvulsive Therapy (ECT):
$750 ECT Treatment only: Anesthesia and other professional services associated with ECT will be billed separately.

Partial Hospitalization Program (PHP):
$500 Per day
$650 Eating Disorder PHP self-pay rate

Therapeutic Injections:
$10 Per Injection
$150 Ketamine Injection

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT

Signature of Patient _____ **Date** _____

Signature of Financially Responsible Party _____ **Date** _____

Relationship of Financially Responsible Party to Patient _____

LCOH Witness Signature _____ **Date/Time** _____