Lindner Center of HOPE
Professional Associates

FINANCIAL RESPONSIBILITY AGREEMENT
SELF PAY SERVICES

Patient Name: _____ **MR#** _____ **Date:** _____

Financially Responsible Party: _____
(if other than Patient)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT FOR SERVICES NOT COVERED BY INSURANCE:
Lindner Center of HOPE Professional Associates (LCOHPA) 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.

I acknowledge that I am financially responsible for all charges associated with health care services provided by LCOHPA to me (or the patient named below) not covered by insurance. I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

The charges listed below are not a full listing of charges but represent the most utilized by provider type. The discount for physician services calculated under the AGB guidelines is 40% for patients that reside in Ohio. For patients residing outside Ohio the self-pay discount is 25%. Such discount will show up on our patient statement as applicable.

		MD	PHD	NP	LISW	Therapist
cpt code	Description	Price	Price	Price	Price	Price
90791	PR PSYCHIATRIC DIAGNOSTIC EVALUATION	330	297	297	297	297
90792	PR PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	370	333	333	333	333
90832	PR PSYCHOTHERAPY W/PATIENT 30 MINUTES	145	131	131	131	131
90833	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	135	122	122	122	122
90834	PR PSYCHOTHERAPY W/PATIENT 45 MINUTES	200	180	180	180	180
90836	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN	175	158	158	158	158
90837	PR PSYCHOTHERAPY W/PATIENT 60 MINUTES	280	252	252	252	252
90838	PR PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN	220	198	198	198	198
90839	PR PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	285	257	257	257	257
90840	PR PSYCHOTHERAPY FOR CRISIS EACH ADDL 30 MINUTES	135	122	122	122	122
99212	PR OFFICE/OUTPT VISIT,EST,LEVL II	105	95	95	95	95
99213	PR OFFICE/OUTPT VISIT,EST,LEVL III	170	153	153	153	153
99214	PR OFFICE/OUTPT VISIT,EST,LEVL IV	240	216	216	216	216
99215	PR OFFICE/OUTPT VISIT,EST,LEVL V	330	297	297	297	297

Other Services: _____

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE.
I am the patient or am legally authorized to sign this document. I have read and understand this Consent for Self-Pay Services.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian

_____
Relationship of Legal Guardian to Patient

_____ _____
Signature of Financially Responsible Party Date

_____ _____
LCOHPA Witness Signature Witness Date/Time