LINDNER
CENTER OF HOPE

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

SIBCY HOUSE ADMISSION 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 acknowledge that I am financially responsible for all charges associated with services provided to the patient named below through the Sibcy House program. I understand that payment outlined below is due in full prior to admission to The Sibcy 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. 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. 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 10 days. **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 Sibcy House services are an elective self-pay treatment program. I understand I am financially responsible for the payment of these services.**

SIBCY HOUSE ADMISSION SELF PAY PROGRAM PRICING:

(Indicate program patient is entering)

☐ Comprehensive Diagnostic Assessment and Treatment Program (up to 28 days) $59,000 / Suite $61,000
Start Date _____ End Date _____
Tentative Discharge Date _____

☐ Initial Treatment (no CDA) (28 days) $50,000 / Suite $52,000
Start Date _____ End Date _____
Tentative Discharge Date _____

☐ Comprehensive Diagnostic Assessment (up to 10 days) $27,500 / Suite $29,500
Start Date _____ End Date _____
Tentative Discharge Date _____

☐ 7 Day Transitional Week (returning patients only) $12,250 / Suite $14,250
Start Date _____ End Date _____
Tentative Discharge Date _____

☐ 10 Day Detox/Stabilization $23,200 / Suite $25,300
Start Date _____ End Date _____
Tentative Discharge Date _____

☐ Daily Rate (for day-to-day extensions) $1,750 x _____ = _____
Suite $1,850 x _____ = _____
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

☐ Williams House to Sibcy House Extention/transition Week with Testing $17,000 / Suite $19,000
Start Date _____ End Date _____
Tentative Discharge Date _____

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: _____