FINANCIAL AGREEMENT

SELF-PAY – Payment is expected to pay at the time of service. Intake assessments are charged at a rate of $200.00. The standard rate is $110 per session (53-60 min). Rates may differ depending on the therapy format. There is a charge for telephone consultations that exceed 15 minutes. Rates and fees will be discussed before treatment starts.

NETWORK PARTICIPATION – If we participate with your insurance plan, we will verify your network benefits and submit claims after each service is rendered; your insurance carrier will pay us accordingly. Payment, however, is your responsibility regardless of insurance coverage and you will be expected to pay any balances on your account if a claim is returned as not paid. Note: If your plan requires an authorization, please obtain it directly from your insurance company prior to starting treatment.

THIRD-PARTY VENDORS – If you are receiving treatment through a third-party vendor Wilmington Mental Health has an agreement with, you must know that any "promise to pay" not satisfied by the vendor is ultimately your responsibility. We will ask you to pay the total balance accrued during your treatment and you will be responsible to collect any reimbursement directly from the vendor.

CREDIT CARD AUTHORIZATION – Please complete this form in its entirety. All patients 18-year-old and older are required to provide a picture ID (school ID, military ID, etc.) for verification to and to prevent insurance fraud.

Name on Card: _____

Address: _____

Billing Zip Code: _____ **Type:** ___ Visa ___ MasterCard ___ American Express ___ Discover

Credit Card #: _____ - _____ - _____ - _____

Expiration Date: _____ / _____ CCV (3-4 digit code) : _____

We accept: 

There is a fee of $35.00 for returned checks. Any standing balance must be paid before treatment is resumed. Refunds cannot be processed once service is provided.

Please keep us informed of any changes in your credit card information or you will be in default under this agreement. Also notify us of any changes in your insurance policy, address, and telephone number.

ATTESTATION: My signature below indicates that I understand that in the event of default, I agree to pay all charges associated with my treatment, including copayments and annual deductibles.

1. I confirm that all information provided on this form is accurate.
2. I give Wilmington Mental Health permission to charge my credit card, bill my insurance company, and request payment for my treatment from third-party companies other than my insurance provider.
3. I authorize Wilmington Mental Health, and/or any of its associates to charge my credit card for any covered service, no-show/late cancellation fees, and any balance that is 30 days overdue.
4. I also understand that if I decide to revoke this privilege and my account is paid up in full, I may withdraw the authorization at any time and will communicate this request by contacting Wilmington Mental Health at 910-777-5575 or by email at info@wmhwc.com.

X _____ _____

Signature of Patient or Representative Date

FOR OFFICE USE ONLY

Revocation note: Date: Staff Initials: