PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Psychiatric, Health & Wellness (PHW) LLC as your healthcare provider. The medical services you seek imply an obligation on your part to ensure payment is made in full for services received. The Patient Financial Responsibility Agreement ("Agreement") will assist you in understanding your financial responsibility. Feel free to ask questions. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses, please share this Statement with them, as it explains to our practice financial policy. The financially responsible person signing this agreement **must be eighteen (18) years or older and be employed**.

**Psychiatric, Health & Wellness, LLC does not participate in any insurance plan. Insurance is the patient's responsibility. Payment is expected in full at the time services are rendered. We do not offer a sliding scale. Payment can be made by credit/debit card. All patients are required to keep a current credit/debit card on file at all times.

Our office will provide you with a detailed invoice which contains all the pertinent information necessary for you to submit your claim to insurance for reimbursement. The rate of reimbursement will depend on your insurance plan and out of network benefits. We do not bill any insurance, supply any information to insurance or communicate with your insurance company. Psychiatric Health & Wellness does not allow insurance to interfere with the patient/provider relationship therefore, no prior authorizations (PA's) for medications are accepted. We recommend you contact your insurance company for eligibility of benefits and other questions related to your reimbursement.

PLEASE READ THIS DOCUMENT THOROUGHLY BEFORE SIGNING
**EACH STATEMENT REQUIRES INITIALS

By acknowledgment of this Statement and/or by receipt of medical services from Psychiatric, Health & Wellness (PHW), LLC, I agree to the following:

1. _____I acknowledge and agree to all FINANCIAL POLICIES of PHW, LLC including the policies available online at www.jadamsandassociates.com Questions about these policies may be addressed to our office staff. These policies may be changed from time to time by PHW, LLC without notice. If there is any conflict between the FINANCIAL POLICIES and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, the FINANCIAL POLICIES shall control.
2. _____I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.
3. _____ Psychiatric Health & Wellness does not participate in any insurance plans. I understand it is my responsibility to submit my claim for reimbursement. I understand ALL communication with my insurance company is my responsibility. Psychiatric Health & Wellness does not communicate with any insurance company.
4. _____I am required to follow all registration procedures, which include updating or verifying personal/financial information.
5. _____ I am responsible for all credit/debit card transaction fees ($5 per individual transaction).
6. _____ I understand Psychiatric Health & Wellness does not offer any financing options or sliding scale.
7. _____I agree to keep updated credit/debit card on file at all times. In the event PHW attempts to charge my credit/debit card and transaction is unable to be processed (card expired, canceled or other), **I agree to pay a 21% per annum charge** until information is updated and credit/debit card is accessible. Any outstanding charges (current charges, interest charges, or other) must be paid in full before any further appointments are made. Payment in full does not include making a payment at the next office visit.
8. _____Any outstanding balance that **exceeds thirty (30) days**, will be turned over to a collection agency. I agree to assume any and all interest charges, attorney fees, collection fees, litigation fees, or any other fees related to collecting remaining balance.
9. _____ As a Patient of PHW (Established or New Patient) if I fail to give a **twenty- four (24) hour cancellation notice** or **do not show up for a telemedicine appointment**, I am responsible for payment in full and authorize PHW to charge my credit/debit card including fees associated with transaction. Late cancellation and no- show visits are not reimbursable by your insurance.
10. _____ I understand PHW "late visit" policy. If I am more than fifteen (15) minutes late for a Telemedicine appointment, I am required to reschedule my appointment and subject to be charged amount of regularly scheduled visit. I authorize PHW to charge my credit/debit card including fees associated with transaction.
11. _____ PHW accepts payment by debit card or credit card (Visa, MasterCard, American Express, Discover. I authorize PHW to securely store my credit/debit card information, and only charge it to satisfy an outstanding balance. The storage system used

is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last four (4) digits of my credit/debit card are viewable by PHW personnel.

12. ____Third-Party Liability Injuries. If I receive treatment as a result of a third-party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because PHW does not protect charges incurred relating to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. PHW will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments. PHW cannot act as administrator to resolve financial arrangements. I understand I am ultimately responsible for payment.

13. Non-Payment on Account -Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, I understand that PHW, LLC has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. I acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on my account and is not deemed interest as part of a credit transaction. If my account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on my credit history; and related portions of my account, including the fact that I received treatment at PHW, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

14. _____Minor Patients (under the age of 18). The parent/legal guardian of a minor is responsible for payment of the minor's account balance. Any minor whose parents are divorced, financial responsibility rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of PHW, LLC.

15. _____Authorization to Contact. I authorize PHW personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in my patient registration information. PHW or any agent of my patient account, may use any information I have provided, including contact information, e-mail addresses, cell phone numbers, and land line numbers, to contact me for purposes related to my account, including debt collection. I authorize PHW to use this information in any manner consistent with the information I have provided, including mail, telephone calls, e-mails, or text messages. I expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if I am charged for the contact.

16. _____Financially Responsible Party. If this or a separate PHW, LLC Financial Responsibility Statement is signed by another person, on my account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt and shall apply only to those services and charges thereafter incurred. By signing as a financially responsible party, I hereby guarantee the full and prompt payment to PHW of all indebtedness of patient to PHW, whether now existing or hereafter created (the "Indebtedness"); and I further agree to pay all expenses, legal or otherwise, incurred by PHW in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of PHW at any time to first exhaust its remedies against me, any other party, or any other rights before enforcing the obligations of the financially responsible party. If the patient is under the age of eighteen (18) a parent or legal guardian must sign this agreement and the **responsible party must be currently employed**.

I understand and agree to all the above information regarding my financial responsibility to Psychiatric, Health & Wellness, LLC and certify all the above with my electronic signature and date.

_____

Print Full Name of Financially Responsible Party

_____ _____

Signature of Financially Responsible Party Date

_____

Print Full Name of Patient