Desert Wise, LLC • 1201 Eubank Blvd NE, Ste. 1 • Albuquerque, NM 87112

Financial Agreement and Credit Card Authorization Form

Patient Name: _____ Today's Date: _____

I understand that I am responsible for understanding the mental health benefits of my insurance plan and for obtaining the necessary authorizations and referrals. In addition, I agree that my financial responsibilities include the following: [**Please initial each section and sign at bottom of the document].**

_____ Payment of $50 for no-shows (i.e., missed appointments without 24-hour advance cancelation). *(The 24-hours does not include weekends. Cancelations are to be completed **24 business hours** prior to appointment time.)* **I understand that my insurance will not cover missed appointments.** This charge is the responsibility of the patient and must be paid in full before future appointments will be scheduled.

_____ Finance charge of 1.5% for accounts not paid in full within 60 days of the date of service

_____ Service charge of $25 each for returned checks, credit card chargebacks, and ACH/electronic bank rejections

_____ Patients paying by insurance:
Co-pays and deductibles are due at the time of service and will be charged to your credit card on file, unless you provide alternate payment at the time of service.

_____ Patients paying directly and/or patients whose insurance does not cover their mental health claims:
Payment is due at the time of service, at the following rates – plus 7.5% tax:

- $275 per initial intake session (45 – 90 minutes)
- $200 per 60 min therapy session (53 – 65 minutes)
- $175 per 45 min therapy session (38 – 52 minutes)
- $125 per 30 min therapy session (16 – 37 minutes)
- $250 per hour for psychological testing and comprehensive learning assessments
- $250 per hour for other services such as letters in which clinical information is discussed, communication with other professionals, and services provided by telephone
- Rates for preparation of reports to be used for legal purposes and for Dr. Henrie's attendance at legal proceedings must be quoted in advance.

_____ Desert Wise is committed to reducing waste and inefficiency through making our billing process as simple and easy as possible. We require that all patients maintain a valid credit card on file with our office.

Credit Card Type:	□ Visa □ MasterCard □ Discover □ American Express		
Cardholder Name: *(Exactly as it appears on card)*		**Expiration Date:**	
Credit Card Number:		**Security/CV Code on Back of Card:**	
Cardholder Billing Address:			
By signing below, I authorize Desert Wise, LLC to keep my signature on file and to charge my credit card for services rendered by Joye Henrie, Ph.D. (DBA: Desert Wise, LLC) and other charges (e.g., no shows, as defined above) billed to my credit card according to the fee schedule and policies presented above.			
Cardholder Signature:		**Date:**	

_____ I agree not to dispute charges for sessions I have received or that I have not canceled 24-business-hours prior to a scheduled session. I further authorize Desert Wise, LLC to disclose information about my attendance/cancelation to my credit card issuer if I dispute the charge.

_____ Past due/overdue accounts may be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling or attending additional appointments.

_____ Informed Consent: I have been provided with, read, and agreed to Desert Wise's Privacy Policy (*DW-001*) and Informed Consent (*DW-002*) prior to signing this document (i.e., Financial Agreement and Credit Card Authorization Form).

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date

Insurance Information:

For those seeking insurance payment for services, complete the following section. *(Direct payers skip the rest.)*

Insurance Company:			
Plan Name:		Group Number:	
Policy Holder's Name:		ID Number:	
Policy Holder's Employer:			
Address of Insurance Company:			

Insurance Billing:

_____ We are happy to file a claim to your primary insurance company as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. Any amount not covered by your insurance policy is due immediately after you receive your first invoice from us.

_____ Most insurance companies **do not** reimburse for written materials or phone calls. Desert Wise **does not** submit claims for this service to the insurance company. The patient is responsible for full payment.

_____ Release and Assignment: I give Joye Henrie, Ph.D. (DBA: Desert Wise, LLC) my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for various health care operations.

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date