FARRAR & ASSOCIATES
MENTAL HEALTH

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FINANCIAL POLICY and PAYMENT METHOD SELECTION

We want to help you make informed decisions about how you pay for your health care. You have the option of having us submit charges to your insurance company or paying the lower self-pay rates in full at the time of service. Please compare the rates in the chart below, read the financial agreement terms, select the option you prefer, and sign this document. You will need to select the self-pay option if your insurance is out-of-network with Farrar and Associates Mental Health (FAMH).

Type of Service	Option 1: Insurance Fee	Option 2: Self-pay Fee
Initial Assessment, Psychotherapy Only	$560	$360
Initial Assessment with Medication Management	$560	$463
Psychotherapy Follow Up	$291-$508*	$240*
Medication Management Follow Up	$265-$492*	$240-$330*
Psychotherapy add-on to Medication Management	$256-$413*	$120-$218*

** Fees vary based on time spent providing service. Fees for some uncommon procedures are not listed here. Please contact us with questions about specific charges.*

For all patients:

I understand I need to **notify FAMH immediately of any changes** to my insurance or preferred payment method, and the selected payment option **cannot be changed *after* service** has been provided and billed. I have the option to change the payment option at any time for *future* services by signing a new financial agreement. Only rare exceptions will be made to this payment election agreement and are solely at the discretion of FAMH.

I understand that I have the option of keeping a **credit/debit card** on file in the secure record system. If I choose to do this, any fees due at the time of service will be **automatically charged** to this card unless I direct otherwise.

I understand that in order to use **telehealth** services, I must either **make arrangements for payment** prior to the appointment or have an active credit/debit card on file and consent to automatic payments.

I understand that if I do not provide at least 24 hours of advance notice for an appointment cancellation, or do not attend my scheduled appointment, I will be charged a **no-show/late cancellation fee of $100**. I understand insurance will not pay this fee. Please see the Patient Expectations document for details.

<u>Option 1: I am choosing to have Farrar and Associates submit charges to my in-network insurance</u>

I have health insurance and authorize Farrar and Associates to **submit charges to my in-network insurance** company or third party carrier.

I understand that **I am responsible for determining whether mental health services at FAMH are covered** by my health insurance plan. I can verify this by contacting my insurance company.

I understand that if my **insurance will not pay** for the services provided, I am financially responsible for the unpaid charges at the rates billed to insurance.

I understand it is my responsibility to **alert FAMH immediately of any changes to** my insurance enrollment status. I understand that if I have elected this option, but have not provided up-to-date and accurate insurance information, I will be responsible for full payment of the rates billed to insurance.

I understand that if I have a **high deductible plan*** and have not yet reached my deductible, I will need to make a **partial payment of $200 at the time of service**. I understand that once FAMH has been notified by my insurance that my deductible has been met, I will no longer be expected to make this partial payment.

*2026: Updated IRS definition of a high deductible is $1,700 or more for individual coverage, $3,400 or more for family coverage.

I understand that I am responsible for the payment of **copays** at the time service, and these charges may continue even after the deductible has been met, per the terms of my insurance plan. I understand that if I have a credit/debit card on file and am receiving **telehealth services**, the card will be **automatically charged** for these payments at the time of service.

I also understand that I will be expected to **promptly pay** the remainder of the balance once it has been processed by my insurance.

I understand FAMH will **refund** any excess payments within 60 days, unless charges are still pending with my insurance.

I give Farrar and Associates **permission to submit any additional information** necessary to process my insurance claim if requested by my insurance carrier.

FAMH will **honor all discounted fee schedules** and network participation pricing as per our signed contracts with insurance companies.

_____	_____	_____
Print name of financial responsible party	Signature	Date

<u>Option 2:</u> I have out-of-network insurance, do not have insurance, or do not wish to have Farrar and Associates bill my insurance.

I understand that in order to select the lower self-pay rates, I agree to **pay in full at the time of service**.

I understand that if I elect to use the self-pay rates, FAMH will **not be responsible for submitting claims** to or otherwise interacting with my insurance company.

I understand that in order to use telehealth services, I must either **make arrangements for payment** in full on the day of the appointment, or have an active credit card on file and consent to automatic payments in full on the day of the appointment.

I understand that I may request a receipt of charges from FAMH and may choose to submit the receipt to my insurance company for direct reimbursement. These charges may or may not be reimbursed, depending on the terms of the insurance plan. I understand that FAMH will not assist with interactions with my insurance company beyond providing me with a receipt.

_____	_____	_____
Print name of financial responsible party	Signature	Date