MILESTONES
CLINICAL & HEALTH RESOURCES
WWW.MILESTONESCLINIC.COM
a division of Stone Belt

PATIENT/CLIENT AGREEMENT

Effective 06/01/2014

INSURANCE and MEDICAID / MEDICARE BENEFITS:

If you (or your dependent) have private insurance or/and Medicaid / Medicare (referred to as "your insurance company"), Milestones will bill your insurance company directly for these services. Milestones will follow the protocols established by your insurance company regarding fees, co-pays, co-insurance, approvals, and deductibles. We will need your insurance company information to accurately bill on your behalf. If your insurance company recognizes Milestones as a network provider, we agree to accept your insurance payment and any contractual adjustments. Patients/parents are expected to pay all co-payment, co-insurance and/or deductible balances at the time of service.

MEDICAL RECORDS: In accordance with the Indiana State Statute IC 16-39-9-4, Milestones will provide copies of records in accordance to HIPAA and for the following fees unless providing records to another provider:

- $20.00 labor fee which includes the first 10 pages
- $0.50 per page for pages 11-50
- $0.25 per page for pages51 and higher
- $10.00 rush fee if records are to be provided within 2 business days
- Actual mailing costs
- $20.00 certifying fee if requested

FEE SCHEDULE/CHARGES:

$ 10.00	90785	Interactive Complexity - Add-on
$ 150.00	90791	Diagnostic Eval w/o Med Services
$ 250.00	90792	Diagnostic Eval w/Med Services
$ 75.00	90832	Psychotherapy 30 min
$ 50.00	90833	Psychotherapy 30 min - Add-on
$ 100.00	90834	Psychotherapy 45 min
$ 75.00	90836	Psychotherapy 45 min - Add-on
$ 150.00	90837	Psychotherapy 60 min
$ 100.00	90838	Psychotherapy 60 min - Add-on
$ 100.00	90846	Family Psychotherapy w/o Patient
$ 100.00	90847	Family Psychotherapy w/Patient
$ 65.00	90853	Group Therapy
$ 50.00	99211	Established Patient MD Eval Lev 1
$ 75.00	99212	Established Patient MD Eval Lev 2
$ 100.00	99213	Established Patient MD Eval Lev 3
$ 150.00	99214	Established Patient MD Eval Lev 4
$ 250.00	99215	Established Patient MDEval Lev 5
$ *10.00	Letters	Pt Requested Letters/Statements*

*Does not include free work/school notes.

There are additional fees for court appearances, subpoenas, dispositions, etc. You may request a copy at any time.

***PRIVATE PAY*:** If you (or your dependent) do not have insurance or Medicaid/ Medicare on the date of service, you are considered a private pay client. Full payment is expected at the time of service.

YES, PLEASE BILL MY INSURANCE:

I hereby authorize Milestones to directly collect all insurance benefits to which I would be entitled as a result of my receiving services by Milestones, its agents, and employees.

I further request and authorize Milestones, its agents and employees, including my therapist, to release to my insurance carrier a copy and/or summary of my mental health records as requested by my insurance company to process my claim. I further certify that the information given by me in applying for payment under any state or federal program is correct. If my insurance carrier pays me instead of Milestones, then I agree to personally pay Milestones any outstanding balance for services rendered. I understand I am responsible for any Coordination of Benefits requests from my insurance which will delay the payment process from my insurance; therefore, I agree to respond in a timely manner to such requests.

ACKNOWLEDGE OF RESPONSIBILITY:

I hereby agree that I am personally responsible for the balance of my/my dependents charges. I agree that I will pay, in full, the balance on the account after insurance payments, deductibles, contractual adjustments, co-insurance and/or copayments have been applied. If my account becomes delinquent (defined as a past due amount for more than 30 days), I understand that it may be referred to a collection agency (Bloomington Accounts Services). I understand that I shall be responsible for any fees and costs required to collect these payments, including but not limited to, court costs and Milestones' reasonable attorney's fees, to which may be added interest at the current legal interest rate.

PATIENT'S NAME AND DATE OF BIRTH:_____

TODAY'S DATE:_____

*Parent/Guardian Signature: _____ Printed Name: _____

****This person is responsible for the bill which should be mailed to:***

Address:_____ ***City:***_____ ***Zip:***_____

U105 Attachment

***A copy of this agreement will be provided to you upon request.*