Procedures and Financial Policy Agreement
For Fortitude Therapy and Wellness, PLLC
Lavonne Bryan, MA, LMHC

OFFICE HOURS: Monday –Thursday 8:30 am- 7:00pm and Friday 8:30 am-5 pm. Our telephone is connected to the pager/cell phone for therapist, Lavonne Bryan. Messages can be left on the confidential voice mail or email at Lavonnebryan@fortitudetherapy.com. Your call will be returned as soon as possible. The Crisis Clinic is also available 24 hours a day, 7 days a week. The number is (206) 461-3222. If it is an emergency, please call 911.

MENTAL HEALTH RECORDS: All your records are confidential. No information will be released (even to family) without your signed consent on a release of information. If you authorize us to release information to others, this process may take up to (2) weeks. Please review the HIPAA Private Policy Notice for a full disclosure of how your health information will be managed.

APPOINTMENTS

We will schedule our appointments via email or phone, or in person at the end of a session. Please notify me via email at Lavonnebryan@fortitudetherapy.com or phone/text, at (206) 354-7971, as soon as possible if you have any schedule conflicts or emergencies which would require you to cancel our appointment. I will notify you ASAP if I should need to cancel our appointment. When you arrive for an appointment, please remain in the waiting room and I will promptly meet you. Full session fees charged for any sessions that are shortened due to late arrival or early departure. I cannot accommodate making up for lost session time unless it is due to my error.

FINANCIAL POLICY

All fees are due at the time of the session, including co-pays. If you are insured, we will bill your insurance company for that part of the fee that is covered. In some instances, you only need to pay your co-payment and deductible if applicable, as we will get direct reimbursement from the insurance company. If you are not insured, then the entire fee is due at each session. Fee is payable by check, debit/credit card, or cash. Statements or receipts are provided monthly and can be provided upon request. Any balance unpaid after (60) days will accrue a 1.5% finance charge per month and appropriate financial payment arrangements made. Balances not paid after (120) days will be turned over to COLLECTION. We charge a $35.00 fee for all returned checks, RCW62A.3 515520.

FORMS OF PAYMENT

I accept cash, check, and debit/credit card payments. Checks should be made payable to: Fortitude Therapy and Wellness, PLLC. Payments are due directly to me at the time of service (at the end of each session). You may also fill out a payment pre-authorization form to allow automatic card payments on the date of your appointment. If payments are not made in a timeframe we have agreed upon, I may notify debt collectors as noted in the financial agreement. I will charge a $35 fee for any returned checks.

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RATES AND FEES

- Individual, Couples or Family Psychotherapy Session (50minutes) $120
- Individual, Couples or Family Psychotherapy Session (90 minutes) $185
- Home or Hospital Visits $160
- Billing forms to your primary insurance company and client $ 0
- Written correspondence, Narrative reports or disability claims (will be prorated for time) $120 per hour
- Phone sessions billed at Psychotherapy Session rates listed above**
- Phone calls/Case management under 15 minutes $0
- Limited SLIDING SCALE fee sessions available. This fee is based on income, affordability and availability.

INSURANCE

I am an in-network/preferred provider Regence Blue Shield. There is no guarantee that I will be covered by your insurance policy. For all other insurance providers, I am out of network and do not bill insurance directly. I can provide you with a receipt that you can submit to your insurance company for reimbursement. Receipts/Invoices are sent at the end of each calendar month, but can be sent sooner upon request. If an insurance claim is denied for any reason other than my error, you are responsible for the remaining balance on your account. Additionally, insurance companies will only pay for services rendered. Therefore, you will be responsible for the full fee for any missed appointments.

CONFIDENTIALITY

Email, Cell Phone, and Fax Communication: Please be aware that email, fax and cell phone communications may possibly be accessed by unauthorized people and the privacy and confidentiality of such communication can be compromised. Please notify the therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use email or faxes for emergencies.

Confidentiality and privileged communication remain the rights of all clients according to a state law. If a client wants information released to another resource, they must sign an authorization to release information form. Many of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices.

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CLIENT AGREEMENT

I understand and accept the terms of the above Procedures and Financial Policy for Fortitude Therapy and Wellness, PLLC/ Lavonne Bryan, MA, LMHC. I understand I am individually responsible for payments of all charges. I have had an opportunity to view the **NOTICE OF PATIENT PRIVACY PROTECTION.** I am aware that this Financial Policy and Privacy policy may change, without notice. I understand that fees charged may be partially discounted due to a preferred insurance plan or other contract.

Signature_____ Date: _____

Print Name_____

Parent/Legal Guardian Signature _____ Date: _____
(if under 14 years old)

Procedures and Financial Policies
Fortitude Therapy and Wellness, PLLC
Lavonne Bryan, MA, LMHC
1421- 34th Ave. Suite 205
Seattle, WA 98122
206-354-7971
Lavonnebryan@fortitudetherapy.com

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INSURANCE RELEASE

I, _____ authorize the Release of Medical Information necessary to process the claim and request payment benefits to the party who accepts assignment. If I do not pay my fee in full, I authorize payment of medical benefits to the supplier (therapist) for services described on insurance form. I hereby authorize said assignee to release all information necessary.

Signature_____ Date: _____

Print Name_____

Parent/Legal Guardian Signature _____ Date: _____
(if under 14 years old)

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