Wellspring Center, PLLC
1968 NC Hwy 172
Sneads Ferry, NC 28460
Phone: 910-327-0800
Fax: 888-728-0060

Fee Agreement

Payment for services at Wellspring Center, PLLC is due when services are provided. As a courtesy we will bill Tricare, and we bill BCBS, in accordance with information you provide to us but you, the client, are ultimately responsible for verifying your coverage prior to seeking our services. We are not Medicaid or Medicare providers. In cases where a third-party payor does not cover our services or coverage has not been guaranteed, you will be asked to pay in full for visits until such time your insurance company does provide verification that it will cover part or all of your costs. In cases where your insurance company reimburses you (the client) directly instead of the provider (Wellspring), you will be expected to pay for services in full up front at the time of the visit. For plans for which Wellspring is an out-of-network provider (except Tricare), it is not possible for us to file your claims for you. We will be happy to provide you with required information to assist you in the filing of your claims. You are obligated to pay any deductible or co-pay required by, or charges not covered by, your insurance plan at the time of service. You remain legally responsible for all charges regardless of insurance coverage.

Charges are based upon the type of service provided to you. There is a $125/hour charge for all therapy appointments. Failure to appear or to provide 24-hour notice of cancellation will result in a $50 charge for the first two occurrences. The late cancellation and no-show fee for any subsequent occurrence will be the full rate of $125. A recurring pattern of missed appointments will result in discharge from treatment. If additional time or services such as extended sessions or after-hours contacts are provided, a fee may be charged; fees charged for non-business hour and holiday services are generally higher. There will also be a charge of $25 per 15 min for completion of lengthy detailed reports, clinical reviews, forms or letters.

It is understood that this financial agreement will continue as long as services are provided to you by Wellspring Center, PLLC and its agents or until such time as you notify us that you wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. When an account becomes 60 days past due, professional collection may be utilized and/or legal action taken.

My signature below indicates that I have read and understand this fee policy. I agree to take responsibility for all fees charged to my account.

_____

Client's Name (print)

_____ _____

Signature of client or client's legal representative Date