Aligned Clinical & Educational Services (ACES), PLC
CROZET MAILING ADDRESS: P.O. Box 28, Crozet, VA 22932
RICHMOND MAILING ADDRESS: P.O. Box 31436, Henrico VA 23294
CROZET OFFICE: 300 Claremont Lane, Suite 103, Crozet, VA 22932
RICHMOND OFFICE: 8100 Three Chopt Road, Room 127, Richmond, VA 23229
PHONE: (434) 466-1588 VP: (434) 326-1496 FAX: (866) 289-5249

ACES FINANCIAL INFORMATION & PAYMENT CONSENT

Name of Client: Date of Birth:

RESPONSIBLE PARTY AGREEMENT AND AUTHORIZATION OF PAYMENT

For All Clients (Please review the following information before signing this document):

- If the client wishes to take advantage of their health insurance benefits, it is the duty of the responsible party to contact the health insurance plan to determine and to understand the client's benefits and contracted financial responsibility.
- It is the duty of the responsible party to provide the client's health insurance information prior to or on the first date of service. If the client's health insurance changes at any point during treatment, the responsible party must inform ACES so that charges and billing can be adjusted appropriately. Failure to update insurance may result in denied or unpaid claims.
- If the responsible party opts to have a debit/credit card on file, they are agreeing to allow ACES to charge the card for services rendered.
- The responsible party must determine and obtain any necessary referrals and/or prior authorizations. Failure to do so may result in a denial and/or unpaid claims from the insurance company.
- Any balances that remain unpaid for 45 days past the due date will accrue 5% interest per month.
- Any statements received after services have been rendered, including balances due to denied or unpaid insurance claims, are due upon receipt.
- Educational services are not covered by health insurance plans, and therefore, will not be billed to the client's insurance.
- A $30.00 fee will be charged for any returned checks.

CANCELLATIONS

Aligned Clinical & Educational Services, PLC is committed to providing all of our clients with exceptional care. When an appointment is canceled without giving enough notice, it may prevent other people from accessing necessary care.
Please notify us at least 24 hours prior to your scheduled appointment for cancellations or changes.

- If the client has a fever over 100°, is vomiting, has diarrhea, has a rash, or is too sick to attend school/work their therapy session will need to be canceled
- If prior notification is not given for cancellation, you will be charged the full session fee for the missed appointment. Charges will not be pursued if prohibited by contractual agreements for specialty services.
- For initial psychiatric evaluations, appointments canceled with at least 24 hours notice will be refunded the full deposit. Appointments canceled with less than 24 hours notice will not be refunded.
- No cancellation charges will apply if local public schools are closed for inclement weather or if the cancellation is due to personal or medical emergencies.

For Clients Receiving Services from an Out-of-Network Provider:

Payment, in full, is due at the time of service. As a courtesy, ACES will file insurance claims for you, unless you do not wish for ACES to file claims or if you do not have health insurance. Any potential reimbursements should be paid directly to you by your insurance carrier. Should you arrive late to a psychotherapy session, ACES can only submit a claim to your insurance for the time that you actually meet with the provider. However, the responsible party is financially obligated to pay for the time originally scheduled for the session.

For Clients Receiving Services from Susi Wilbur, LCSW as an In-Network Provider:

The responsible party will owe the client's coinsurance or copayment fee at the time of service. Any outstanding balances after insurance payments are processed will be billed to the responsible party.

ACES FINANCIAL INFORMATION & PAYMENT CONSENT

For Clients Receiving Specialty Services via Prearranged Network-Level Authorization and/or Single-Case Agreement:
The responsible party will owe the client's coinsurance or copayment fee at the time of service. Any outstanding balances after insurance payments are processed will be billed to the responsible party.

For Clients with TRICARE Insurance:
Some ACES providers are registered with TRICARE as non-participating non-network providers. Services from these providers are charged at the TRICARE allowable rate plus 15%. Payment, in full, is due at the time of service. As a courtesy ACES will submit your claims to TRICARE for reimbursement. TRICARE will then reimburse you directly the full TRICARE allowable rate determined by your individual TRICARE plan, minus the 15%.

Do you wish for ACES to file claims for billable services to your health insurance carrier?

☐ NO, please do NOT file claims to insurance. ☐ YES, please DO file claims to insurance.

HEALTH INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Insurance Carrier:	Insurance Carrier:
Name of Subscriber:	Name of Subscriber:
Subscriber DOB *(MM/DD/YYYY):*	Subscriber DOB *(MM/DD/YYYY):*
Plan Effective Date *(MM/DD/YYYY):*	Plan Effective Date *(MM/DD/YYYY):*
Member ID:	Member ID:
Group ID:	Group ID:

I, as the responsible party, request **Aligned Clinical & Educational Services, PLC.** file claims with my insurance company on my behalf.

Name of Responsible Party: _____

Relationship to the Client: _____

Signature: _____ Date: _____

CREDIT CARD ON FILE AGREEMENT
ACES offers the option for clients to store their credit card information within our billing system. This enables payment to be collected automatically in an effort to reduce time and effort spent, as well as the potential risk of late fees for clients. Providing your credit card information allows the convenience of payment for your services. A copy of your receipt will be available for download through your Patient Portal account. If you would like to keep your credit card on file, please provide us with your credit card information and sign below.

Do you wish for ACES to keep your credit card on file and automatically collect payment for services rendered?

☐ NO, please do NOT keep my credit card on file. ☐ YES, please DO keep my credit card on file

I authorize ALIGNED CLINICAL & EDUCATIONAL SERVICES to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I understand that this agreement will remain in effect until the expiration of the credit card account and that I may revoke permission to charge my credit card automatically at any time in writing.

Credit Card Information

Aligned
CLINICAL & EDUCATIONAL SERVICES, PLC

ACES FINANCIAL INFORMATION & PAYMENT CONSENT

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yy):	Cardholder ZIP Code (from credit card billing address):

I authorize ALIGNED CLINICAL & EDUCATIONAL SERVICES to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I understand that this agreement will remain in effect until the expiration of the credit card account and that I may revoke permission to charge my credit card automatically at any time in writing.

Name of Responsible Party: _____

Relationship to the Client: _____

Signature: _____ Date: _____

ALIGNED CLINICAL & EDUCATIONAL SERVICES RATE SHEET

BEHAVIORAL HEALTH SERVICES				
Service	**CPT Code**	**Psychiatrist**	**Clinical or School Psychologist**	**Licensed Clinical Social Worker**
New Client Diagnostic Clinical Interview	90791	$250	$250	$200
New Client Diagnostic Clinical Interview	90792	$400		
Use of one psychological assessment measure in support of therapy services (including up to 3 raters on one scale)	96146	$50	$50	$50
Individual Therapy	90832 (16-37 min)	$150	$110	$85
	90834 (38-52 min)	$160	$160	$125
	90837 (30-74 min)	$215	$215	$165
Family Therapy	90846, 90847	$215	$215	$165
Crisis Therapy	90839 (first 60 min)	$300	$215	$165
	90840 (each additional 30 min)	$175	$120	$100
Medication Management for Established Clients	99212 (10-19 min)	$80		
	99213 (20-29 min)	$150		
	99214 (30-39 min)	$150		
	99215 (45-54 min)	$225		
Individual Therapy add-on to medication management appointment	90833 (16-37 min)	$30		
	90836 (38-52 min)	$75		
Comprehensive Record Review	Not reimbursable by Insurance (per 60 min)	$300	$215	$165
Form Completion (Accommodations, FMLA, DA, etc.)	Not reimbursable by Insurance (per 15 min)	$75	$55	$50
Behavioral Health Phone Consultation	Not reimbursable by Insurance (per 15 min)	$75	$55	$41.25
All Court Appearances and Preparation	Not reimbursable by Insurance	$400/ hour	$350/hour	$300 / hour
		$3,200 for a full day in court	$2,800 for a full day in court	$2,400 for a full day in court

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PSYCHOLOGICAL ASSESSMENTS			
Service	**CPT Code**	**Clinical or School Psychologist**	**Assessment Technician / Related Provider**
Developmental test administration with interpretation and report	96112 (first 60 min)	$215	
	96113 (each additional 30 min)	$110	
Psychological testing evaluation services including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the client, family member(s) or caregiver(s).	96130 (base code)	$215	
	96131 (each additional 60 min)	$215	
Psychological or neuropsychological test administration and scoring by a clinical or school psychologist	96136 (first 30 min)	$100	
	96137 (each additional 30 min)	$100	
Psychological or neuropsychological test administration and scoring by an assessment technician	96138 (first 30 min)		$75
	96139 (each additional 30 min)		$75
Educational test administration and scoring	Not reimbursed by insurance (per 60 min)	$215	
Meeting with IEP team or other school staff to review testing results	Not reimbursed by insurance (per 60 min)	$215	$150

RELATED SERVICES				
Service	**CPT Code**	**SLP / OT**	**Clinical or School Psychologist**	**Board-Certified Behavior Analyst**
Speech Language Pathology Assessment	92523	$550		
Occupational Therapy Assessment	97167	$300		
Functional Behavior Assessment	97151 (per 15 min)			$37.50
Classroom Observation	Not reimbursable by Insurance (per 60 min)	$150	$215	$150

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I, as the responsible party, understand and agree to pay for clinical services at the rates and timeline described. I authorize any applicable payment of medical and/or behavioral health benefits to the provider of services, Aligned Clinical & Educational Services, PLC.

Name of Responsible Party: Date of Birth:

Relationship to the Client:

Billing Address:

Signature: Date: