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.

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CLINICAL & EDUCATIONAL SERVICES, PLC

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ACES Out-of-Network Providers have also opted out of Medicare. This means that payment is due, in full, at the time of service for Medicare beneficiaries. Beneficiaries agree not to submit any claims to the Medicare program for any item or service delivered by an ACES out-of-network provider. ACES out-of-network providers agree not to receive any reimbursement from Medicare for any item or service, directly, indirectly, or on a capitated basis for services provided for patients who are Medicare beneficiaries, and no Medicare payment may be made to any entity for services.

By signing this document, ACES clients agree to enter into a private contract to receive services from a provider who has opted out of Medicare services and understand that they will pay out of pocket rates without any reimbursement from Medicare. This consent acknowledges that fees for services may be greater than the limiting charges established by Medicare. All clients have the right to seek services from other providers if they wish to obtain reimbursement through Medicare.

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
Insurance Carrier:
Name of Subscriber:
Subscriber DOB*:*
Client Relationship to Subscriber:
Subscriber Address:
Plan Effective Date *(MM/DD/YYYY):*
Member ID:
Group ID:

Secondary Insurance
Insurance Carrier:
Name of Subscriber:
Client Relationship to Subscriber:
Subscriber DOB*:*
Subscriber Address:

ACES FINANCIAL INFORMATION & PAYMENT CONSENT

Plan Effective Date *(MM/DD/YYYY):*
Member ID:
Group ID:

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

Signature: Date:

CREDIT CARD ON FILE AGREEMENT

ACES requires that clients provide a credit card to be kept on file in 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. A copy of your receipt will be available for download through your Patient Portal account. The cost for services will be charged to the credit card provided on this form the evening of your scheduled appointment. Should you wish to provide a different form of payment, please call the main office before, or directly after, your appointment to set up the preferred method of payment.

Credit Card Information		
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other		
Cardholder Name (as shown on card):		
Card Number	3-digit CVV code	Expiration Date (mm/yy)
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.

Signature: Date:

ALIGNED CLINICAL & EDUCATIONAL SERVICES RATE SHEET

BEHAVIORAL HEALTH SERVICES						
Service	**CPT Code**		**Provider Type**			
			Psychiatrist	**Clinical or School Psychologist**	**LCSW / LPC**	**MSW, Supervisee in Social Work**
New Client Diagnostic Clinical Interview for Therapy or Testing	90791			$350	$300	$260
New Client Diagnostic Clinical Interview	90792		$500			
Use of one psychological assessment measure in support of therapy services (including up to 3 raters on one scale)	96146		$50	$50	$50	$50
Individual Therapy (Including Play Therapy with a Psychiatrist)	90832	(16-37 min)	$150	$150	$140	$100
	90834	(38-52 min)	$215	$215	$210	$170
	90837	(53-60 min)	$235	$235	$225	$185
Family Therapy	90846	(26-50 min)	$235	$235	$225	$185
	90847	(26-50 min)	$235	$235	$225	$185
Crisis Therapy	90839	(first 60 min)	$300	$250	$245	$205
	90840	(each additional 30 min)	$175	$155	$145	$105
Medication Management for Established Clients	99212	(10-19 min)	$180			
	99213	(20-29 min)	$205			
	99214	(30-39 min)	$205			
	99215	(40-54 min)	$255			
Individual Therapy add-on to medication management appointment	90833	(16-37 min)	$40			
	90836	(38-52 min)	$70			
	90838	(53-60 min)	$95			
Comprehensive Record Review		Not reimbursable by Insurance (per 60 min)	$300	$235	$225	$185
Form Completion (Accommodations, FMLA, DA, etc.)	FORM	Not reimbursable by Insurance (per 15 min)	$75	$58.75	$53.75	$43.75
Submit Prior Authorization Request for Medication	AUTH REQ	Not reimbursable by Insurance (flat fee)	$20			
Behavioral Health Phone Consultation	PHONE CONSUL	Not reimbursable by Insurance (per 15 min)	$75	$59	$50	$44
Court Appearances and Preparation - Per Hour	COURT	Not reimbursable by Insurance	$450	$350	$300	$300
Court Appearances and Preparation - Per Day	COURT DAY		$3,700	$3,200	$3,000	$3,000

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PSYCHOLOGICAL ASSESSMENTS				
Service	**CPT Code**		**Provider Type**	
			Clinical or School Psychologist	**Assessment Technician / Related Provider**
Developmental test administration with interpretation and report	96112	(first 60 min)	$235	
	96113	(each additional 30 min)	$120	
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)	$300	
	96131	(each additional 60 min)	$255	
Psychological or neuropsychological test administration and scoring by a clinical or school psychologist	96136	(first 30 min)	$125	
	96137	(each additional 30 min)	$125	
Psychological or neuropsychological test administration and scoring by an assessment technician	96138	(first 30 min)		$100
	96139	(each additional 30 min)		$100
Educational test administration and scoring	1000	Not reimbursed by insurance (per 60 min)	$235	$235
Meeting with IEP team or other school staff to review testing results	SCH MEETING	Not reimbursed by insurance (per 60 min)	$235	$235
Classroom Observation	OBS	Not reimbursed by insurance (per 60 min)	$235	$235

ALIGNED CLINICAL & EDUCATIONAL SERVICES RATE SHEET

Note regarding guardianship/shared custody:
The individual who signs ACES Financial Information & Payment Consent form will be named the client's "responsible party" and is responsible for payment for services rendered. If there is shared custody (and subsequently shared payment of expenses) it is the responsibility of the party signing this form to communicate with their child's shared custodian, and coordinate payment.

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: _____

Relationship to the Client: _____

Signature: _____ Date: _____