Patient:_____

DOB:_____ **ID:**_____

Private Pay Agreement

I agree that in return for the services provided to me or the patient (if a different person - hereafter the word 'patient' applies to both) by Brain Solutions PLLC or other affiliates, I will pay the account of the patient and/or make financial arrangements satisfactory to Brain Solutions PLLC. Payment for services is due in full at the time services are rendered. If the service is not paid in full at the time of the appointment, the session is subject to cancellation per the discretion of Brain Solutions PLLC. Payment amounts vary and are dependent on the type of services provided. Brain Solution's staff will provide you with an estimate at the time of service.
If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for medical and behavioral health services rendered to the patient if I am ultimately found to be liable for the bill. I understand and agree that a delinquent account will be subject to interest at the legal rate.

I understand and agree that my insurance and/or the patient's' insurance, if any, will **NOT** be billed for services rendered to the patient. I further understand and agree that as part of the normal business communication with Brain Solutions PLLC, with regard to this matter, Brain Solutions PLLC staff or representatives may contact me through any of the following methods: letter, email, telephone, text/voice message, or any other available technologies used by businesses for such communications. It is understood and agreed, however, that the patient and I may be contacted using an auto-dialer during collection proceedings.

If you need to cancel or reschedule an appointment, please provide us with at least a 24-hour notice. **If you miss a scheduled appointment without contacting us for cancellation, or cancel with less than a 24-hour notice, our policy is to assess a $100.00 fee payable to Brain Solutions** [unless you and your provider both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the full fee amount as described above. Brain Solutions reserves the right to suspend services until the fee is paid. **Excessive appointment no shows and frequent late arrivals is grounds for discharge from our services.** This includes cancellations without the required 24-hour notice. This cancellation policy is standard in most medical and behavioral health practices and will be strictly enforced.

In the event that the patient has a payment on an active account, whether through cash, check, credit card or other means, and there remain additional funds available after that account is satisfied (e.g. an overpayment), Brain Solutions PLLC is authorized to apply the overpayment to any other account owed by the patient that remains unpaid. Brain Solutions reserves the right to charge a nominal processing fee for all credit card transactions.

I have read, understand, and agree to adhere to Brain Solutions PLLC's Private Pay Agreement as stated above.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness Date/Time