



**Path to Awareness, PC**  
**Chad Brown, MD and Juliana Ayers, PMHNP**  
**Fee Agreement**

The standard fee at Path to Awareness is \$300.00 per session (45-50 minute session). This fee can be paid in a number of ways. Path to Awareness accepts insurance reimbursements, and patients with insurance coverage are expected to pay their co-pay or co-insurance payment to Path to Awareness prior to each visit, as well as all fees not covered for any reason. If your copay or coinsurance and associated fees are not paid at time of service, a \$9 billing fee may be imposed. Please be aware that your insurance contract is between you and your insurance company. You will be responsible to know the terms and exclusions in your insurance policy, and to ensure your insurance carrier's cooperation with us. If no insurance payment has been received within 60 days of billing, you will be responsible to pay the unpaid balance on your account. If we subsequently receive payment from the insurance company, you will be promptly reimbursed.

**I agree to the following arrangement for payment of fees:**

- |   |   |
|---|---|
| <input type="checkbox"/> 1 <sup>st</sup> Session – Intake/Assessment \$ 300.00<br>(Average) | <input type="checkbox"/> Follow Up Session –30 Min: \$200.00<br>(Average) |
| <input type="checkbox"/> Negotiated Fee – Patient Pays 100% \$<br>_____                     | <input type="checkbox"/> Follow Up Session-60 Min: \$300.00<br>(Average)  |

**Patient Consent to Fee Agreement:**

**Initial**

- \_\_\_\_\_ I have read the above information.
- \_\_\_\_\_ I consent to being treated by Path to Awareness providers.
- \_\_\_\_\_ I agree to pay the contracted fee at the time of service.
- \_\_\_\_\_ I understand I will be responsible for paying missed sessions for which a 24-hour prior notice is not given, and my insurance company may not be billed.
- \_\_\_\_\_ I am fully responsible for all fees assessed to my account.
- \_\_\_\_\_ If my insurance policy or another third-party coverage does not pay my doctor for the services rendered, I am responsible for paying the full amount of the fee (unless otherwise prohibited by insurance company regulations communicated to Path to Awareness as part of the authorization process).
- \_\_\_\_\_ I understand fees for services are to be paid in advance, before my session, unless other arrangements have been made.
- \_\_\_\_\_ Path to Awareness has a legal right to utilize a collection or billing service to collect payment if I fail to pay in full for services received, and to refuse services until such payment is made.
- \_\_\_\_\_ I am aware that Dr. Brown is opted out of Medicare, and cannot bill out services to that insurance company, making me financially responsible for all charges. I agree to choose between a set self-pay rate or have secondary insurance billed should that apply. Should at any time secondary insurance deny claims, I understand I will be financially responsible for those charges.
- \_\_\_\_\_ I have read and understand the conditions upon which my fee has been determined, and I agree to these conditions.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date
_____	_____	_____
Patient Representative (Print)	Patient Representative Signature	Date