FINANCIAL AGREEMENT for SELF-PAY and CONCIERGE PSYCHIATRIC PRACTICE
Healing For All, LLC – Sherri Marie (Simpson) Broadwater MD
Diplomate of the American Board Psychiatry & Neurology Board Certified Adult, Child & Adolescent Psychiatrist

Fee Schedule

$250 – 50 minute psychotherapy and/or psychopharmacology appt in office
$350 - 50 minute psychotherapy and/or psychopharmacology appt out of office.
$350 – 1.0 hour initial intake appt./ 1.5 initial intake for children
$450 - 1.0 hour initial intake appt out of office/ 1.5 initial intake for children
$155 – 30 minute phone, virtual, or in-person wellness appt.
$125 – 20 minute phone, virtual, or in person wellness appt.
$750 - Deposition hourly rate

Ongoing contractual services are billed at the beginning of each month.

VIP Psychiatric services are held in-office or other location, via telephone or via virtual visits:

$2800 - up to 8 hours of scheduled access
$4200 - up to 12 hours of scheduled access
$7000 - up to 20 hours of scheduled access

VIP services allow you the opportunity to personally engage with Dr. Sherri Psych. Dr. Sherri Psych believes that holistic care is the only type of care. While she is an expert in psychopharmacology she is a conservative prescriber of psychotropic medications.

Customized options beyond the above can be made with Dr. Sherri Psych.
One, three, and six month contracts available. Contact Dr. Sherri Psych to discuss a customized plan that suits your needs.

*Travel is included up to 25 miles. Travel is limited during rush hours or during occasions of high traffic.

Full payment is expected for no-show appts and missed appts not cancelled within 48 hour of your scheduled appointment. Your credit card will be charged at the time of the missed, scheduled appointment.

In addition, I have reviewed the complete list of service fees on the practice and I agree to pay such fees when the indicated service is rendered at each visit. ***Initial*** _____

Credit/Debit Card Payment for Professional Services

_____ VISA _____ MasterCard _____American Express
_____ Name as it appears on card
_____ - _____ - _____ - _____ Credit / Debit Card Number
_____Billing Zip Code _____Security Code ____/_____ Exp. Date

I understand that Healing For All, LLC/Dr. Broadwater does not bill insurance in her self-pay and VIP/Concierge practice and I am responsible for payment at each appointment. I am financially responsible for all charges related to my treatment with Dr. Broadwater. In Dr. Broadwater's self-pay and concierge private practice, payment in full is expected at the time of service. We do not verify out-of-network insurance benefits and recommend you do so yourself BEFORE your first appointment and annually. If you have billing questions for our office, please call 844-Heal-ONE. Dr. Broadwater accepts cash, checks, and major credit cards.

I authorize Healing For All, LLC to charge this credit/debit card for any and all patient responsibility portions, fee for the completion of any forms and/or letters I request, prescription refill, collaborating communication, and missed/no-show or late appointment fees. ***Initial*** _____

I certify that I am an authorized signer on the submitted credit card/check and that the credit card number and signature submitted are the same as those on file with the credit card issuer or bank account holder. ***Initial*** _____

Cancellation/No Show and Other Fees
In order to best serve all patients, Dr. Broadwater requires a 48 hour notice to change any appointment. If adequate notice is not provided, the full appointment fee will be charged, regardless of the reason for cancellation.

I understand that I will be charged the full appointment fee if I no - show or cancel with less than a 48 hour notice, and that Dr. Broadwater makes an exception to this policy only for women in labor or unexpectedly admitted in the hospital. I have had all questions about this policy satisfactorily answered and I agree to it. ***Initial*** _____

I authorize Healing For All LLC to charge the above credit card when the patient does not give advance notice for a late-cancellation or no-show, as per the policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly. ***Initial*** _____

Late Payment and Other Penalties

Payment in full is required at the time of service. If for some reason payment is not made at the visit, a $15 billing charge will apply for each invoice or reminder sent. Generally, payment will be required before further appointments can be scheduled. NSF (bounced) checks incur a $35 fee. Accounts that are seriously overdue may be forwarded for collection activity.

If I default and my account is referred to collections, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees.
Initial _____

I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% per month of that outstanding balance. I understand that unpaid balances over 90 days past due may be referred to a collection agency. ***Initial*** _____

Financial Responsibility

I understand that Healing For All, LLC/Dr. Broadwater does not bill insurance in her self-pay and concierge practice and I am responsible for payment at each appointment. I am financially responsible for all charges related to my treatment with Dr. Broadwater.
Initial _____

Guarantor's Signature: _____
Guarantor's Name: _____
Patient name if different from the above:
_____

Date: _____