NeuroScience & TMS
Treatment Centers

We strive to help all patients get well. We want to communicate clearly so that we are transparent about the policies. We believe this is important for patients, and those that are helping them emotionally and financially, to fully understand how the office works, and the charges that could be incurred.

All patients sign office policies upon enrollment and these policies are kept in their Electronic Medical Record.

In this document, the word "patient" refers to the person receiving care or the parent or guardian, when appropriate.

In this document, the word "clinician" refers to the physicians, psychiatric nurse practitioners, and therapists who work in our clinics.

These policies are valid for all the NeuroScience & TMS Treatment Center locations as well as the therapist working under the name Nashville Center for Hope & Healing.

We may update our policies as may be necessary; continued use of our services after an update constitutes consent to the updated policies to the extent permitted by law.

1. ABOUT US

   NeuroScience & TMS Treatment Center

   Thank you for wanting to schedule an appointment. The NeuroScience & TMS Treatment Center is a local, Tennessee, physician owned & operated practice. We have many locations. Each specific location is led by a physician/psychiatrist medical director who has built a team of talented clinicians (physicians, psychiatric nurse practitioners, therapists), technicians and staff to serve our patients. We work as a team and offer many types of services, including psychiatric and therapy evaluations, medication treatment, therapy, and interventional services such as Transcranial Magnetic Stimulation (TMS), Spravato (Esketamine) Treatment, and Vagus Nerve Stimulation (VNS). Our therapy division is called the Nashville Center for Hope & Healing and has in network and out of network, self pay (private pay), therapists. The clinicians (physicians, psychiatric nurse practitioners, and therapists) in our offices are sought after because they work hard to get their patients to the wellness they desire and because they are in-network with many health insurance companies.

   a. We work long hours for our patients, and we want to be transparent with our boundaries and office policies from the beginning.

   b. This document is a summary of the office policies; please read the full copy in the patient portal.

2. OFFICE HOURS

   a. Regular office hours are by appointment only.

   b. Staff answer virtual portal messages, telephone calls, emails, text messages and check patients in and out of the office for appointments from 9 am to 4 pm, Monday through Thursday, and 9am to 3pm on Fridays. We do not ask our staff to work on Federal Holidays, but at times, the clinicians (physicians, psychiatric nurse practitioners, therapists), may have appointments on these days.

   c. Telephone calls to our office may go to our voicemail, if staff are helping another patient, if a call is received after hours, OR if a patient call is received during the lunch hour. Staff check and respond to voicemails, texts, emails, and portal messages regularly during office hours.

   d. We have a 24-hour emergency call line for our patients.

3. CONTAGIOUS ILLNESS POLICY

    a. We have implemented a physical illness policy in the office to keep patients and their families, our families, and all employees and patients in our clinic free of physical illness.

    b. Please notify us before coming into the offices if patients have any contagious illness, or have a fever, cough, or any shortness of breath (strep throat, upper respiratory infections, gastrointestinal viruses, etc.). If patients have these symptoms or have been around anyone who has had a serious viral illness, patients should consider staying at home to avoid spreading the infection. We offer telemedicine/telehealth/virtual visits for patient care if one can not attend an appointment in person.

4. APPOINTMENT REMINDER POLICY

    a. As a courtesy, our electronic medical record can provide appointment reminders via portal messages. In addition, the portal may have your appointment listed. Email or text message reminders can be sent as approved by the patient.

    b. Reminders are not guaranteed, and subsequently,not receiving a reminder does NOT remove the patient's responsibility for charges for missed, or late canceled appointment(s), including New Patient Appointments.

    c. Reminders may be incorrect. For instance, if the patient (or parent or guardian) knows that an appointment is scheduled as telemedicine/telehealth/virtual and the reminder says the appointment is at the office, the appointment may still be telemedicine/telehealth/virtual. It is always best to call or text and check with a Front Office Administrator if the reminder does not match with what was expected.

5. OFFICE APPOINTMENT TYPES & CHARGES POLICY

    Three Important points about Appointment Types and Charges

    a. If the clinicians (physicians, psychiatric nurse practitioners, therapists), seen in our offices are in-network with the insurance company that covers the patient, the office will file charges with the insurance and reductions may be granted based upon the allowed amounts of the in our negotiated contract.

    b. Each individual insurance has a specific contracted rate with us, so our office can not determine the final dollar amount, specifically, a patient will pay for the visit prior to coming to the office.

    c. Each individual clinician (physicians, psychiatric nurse practitioners, therapists), has an assortment of different codes that the clinicians might use and sometimes we will add on codes based upon special assessments that are felt to be medically relevant. Patients may have a copay, co-insurance and deductible for each charge.

    d. The CHARGES for office visits are listed below. These are private pay rates for patients that do not have insurance. We have many different appointment types and different “Self-Pay” (Private Pay) rates for these appointment types. Self Pay is often less expensive overall than insurance rates, as we do not have to do complex, costly insurance billing and follow-up with insurance. We can not charge Self Pay rates if we are in-network (contracted) with your insurance company.

    e. When we file with the health insurance companies with which we are in contract with, patient’s pay the co-pays, coinsurance, and deductibles in accordance with our contracted rates and allowable rates as decided by insurance.

    f. All Insurance companies have "Allowable Rates" for charges and these can vary from our Self Pay (Private Pay) rates. Allowable insurance rates could be lower or even higher than our Self Pay rates. See our Good Faith Estimate section for more details.

i. New Patient Appointment Types & Charges

1. New Patient Evaluation with a Physician/Psychiatrist
    - Duration: 60 to 90 minutes with the possibility of more time for chart review & assessments
    - Self Pay Charge = $495

2. New Patient Evaluation with a Psychiatric Nurse Practitioner
    - Duration: 60 to 90 minutes with the possibility of additional time for chart review & assessments
    - Self Pay Charge = $395

3. Therapy Only Evaluation with a licensed therapist
    - Duration: 60 to 90 minutes with the possibility of additional time for chart review & assessments
    - Not all therapists are in contract (in-network) with all insurance companies. If you need an in-network therapist, please tell the new patient coordinator.
    - Self Pay Charge = $250
    - The Therapist division of our company is called Nashville Center for Hope & Healing

4. Comprehensive Team Evaluations
    - Duration 120 to 180+ minutes
    - There are two options for these comprehensive evaluations:
        - Therapist + Physician Psychiatrist = $745
        - Therapist + Psychiatric Nurse Practitioner = $645

In these evaluations a therapist first will see the patient, and then, a Physician/Psychiatrist or Psychiatric Nurse Practitioner meet with the patient for a total of two to three hours in total; over one to two days, in order to make a thorough evaluation and plan of care for the patient.

The therapy portion of the Comprehensive Team Evaluation may not be covered by insurance if the therapist is out of network, but the Physician/Psychiatrist or Psychiatric Nurse Practitioner portion of the overall evaluation can be billed to health insurance companies which we are contracted (in-network).

ii. Follow Up Appointments Types & Charges

These appointments are conducted face to face, virtual (audio and video), or on the telephone (audio only).

1. Therapist Follow Up appointments
    - Duration: 30 to 50 minutes
    - Self Pay Charge for 30 minutes with therapist = $100
    - Self Pay Charge for 45 minutes with therapist = $165
    - Self Pay Charge for 50 minutes Couples Session with therapist = $175

2. Psychiatric Nurse Practitioner Follow Up appointments:
    - Duration: 20-60 minutes
    - Self Pay Charge for 20-30 minutes with a Psychiatric Nurse Practitioner = $150
    - Self Pay Charge for 45-60 minutes with a Psychiatric Nurse Practitioner = $250

3. Physician-Psychiatrist Follow Up appointments:
    - Duration: 20 to 60 minutes
    - Self Pay Charge for 20-30 minutes with a Physician-Psychiatrist = $250
    - Self Pay Charge for 45-60 minutes with a Physician-Psychiatrist = $375

Other appointments and service charges may include but are not limited to TMS, VNS, or Esketamine Services, Coordination of care, letters, paperwork, prior authorization, brief clinical concerns etc. Some of these services have charges that are a the clinician's (physicians, psychiatric nurse practitioners, therapists), prorated hourly rate, or per an insurance contracted rate. Patients receiving these specialized treatments are given specific financial proposals (Good Faith Estimates) before beginning these treatments.See the Good Faith Estimate section of policies for more details.

SPECIAL NOTE: The Clinicians in the office make efforts to see patients at their appointment time. Situations do arise where additional time is needed to address a specific need with a patient; appointments may be extended as needed for these clinical circumstances. This can cause a clinician to get behind in their schedule and all efforts will be taken to alert patients that follow. Extra time will be billed per our policies, see the Good Faith Estimate section of policies for more details.

6. <u>TELEMEDICINE/TELEHEALTH/VIRTUAL APPOINTMENTS POLICY</u>

a. Telemedicine/Telehealth/Virtual Appointments improve access to care for patients as they can easily access a clinician, for an individual or group encounter. Patients access the telemedicine/telehealth/virtual link for their appointment in our portal.

b. The information obtained during telemedicine/telehealth/virtual appointments will be used for assessment, evaluation, diagnosis(es), education, and treatment. The patient's electronic medical records will likely be accessed during these appointments. These appointments will be hosted on the portal. If this secure technology is unavailable other formats may be offered: audio via telephone call or a doxy.me link.

    i. Delays in appointments could occur because of deficiencies or failures of equipment, or a network failure.

    ii. In extreme cases, security protocols for the virtual platform (Zoom) could fail and cause a breach of personal treatment information.

    iii. A patient, who chooses to use telemedicine/telehealth/virtual appointments, agrees and understands that this form of communication has substantial and inherent security risks and hereby allows such communication. If a patient does not approve of this form of communication, then the patient must refuse such forms of communication and give us notification as such in writing. Face-to-face visits offer the only, more secure alternative to virtual visits.

c. Good clinical care guidelines in our office dictate that face-to-face visits occur at the start of care with clinicians in our office. New Patient Appointments and Comprehensive Team Evaluations are, therefore, not recommended as telemedicine/telehealth/virtual appointments and will not be scheduled as such. Follow up appointments may be scheduled in a telemedicine/telehealth/virtual manner if approved by the clinician after the first face to face appointment.

d. Fifteen minutes before a virtual appointment, the patient should make sure that their phone or computer works and that they log into the patient portal prior. . The best browser to use with virtual appointments is Google Chrome. If the link or your internet are not working, use the office secure text line 615-551-5853 to communicate with staff so that they can provide you a backup virtual appointment link.

e. These virtual appointments are billed as face to face appointments. Most insurance companies cover charges for virtual visits in the same way that they do for face-to-face visits; check with the insurance policy that covers the patient's care for details.

f. Just like face-to-face appointments, virtual appointments with clinicians must comply with state and local laws, and with the insurance coverage for the clinic, and as such, *patients will be required to be within the state lines of Tennessee to be seen by a prescribing clinician (psychiatrist or nurse practitioner) licensed in the state.* If patients fail to honor this part of the Telemedicine/Telehealth/Virtual Appointments Policy, an appointment could be terminated by the prescribing clinician. In this case, patients are responsible for the full cost of the appointment; insurance will not cover these costs.

g. THIS PART of the Telemedicine/Telehealth/Virtual Appointment Policy DOES NOT APPLY TO THERAPISTS; therapists are covered by different licensing boards and malpractice coverage; they are allowed to see patients who are not in Tennessee.

h. If patients have chosen to move outside of Tennessee, they will need to make sure that they will be in Tennessee for virtual appointments or come to see the prescribing clinician face to face, if patients intend to continue care in our office. If patients do not plan to return to our state, they will need to make arrangements to get prescriptions in the state where they are presently living.

i. It is important to note, that missing or late canceling a telemedicine/telehealth/virtual appointment carries the same fees as missing or late canceling a face-to-face appointment.

j. Standard Operating Procedures in our office require that a prescribing clinician see a patient twice per year (face-to-face, in the office) if the patient is prescribed controlled substances. Sometimes, because of clinical necessity, prescribing clinicians may recommend more face to face visits for good clinical care.

7. <u>DEPOSIT</u>

   a. New Patient Deposit

      i. For all new office appointments, we ask for a $27.50 deposit which will be applied to your initial appointment charges.

      ii. We do not waive the deposit. If the patient doesn't owe $27.50 over the course of two appointments, the initial deposit can be refunded or it can be applied to the cost(s) of future appointments. Patients (or parents/legal guardians) are responsible for all other charges over & above the deposit:

         1. If we are out of network with the patient's healthcare insurance, the patient may have additional due at the first visit.

         2. If we are in network with the patient insurance, but the patient has a specific deductible, copayment, or co-insurance, the patient may have additional money due at the first visit.

      iii. If you miss your initial appointment in the office or cancel with less than 72 business hours notification (late cancellation), your deposit will be applied to the missed/late cancellation charge which is the cost of the full visit.

8. COMMUNICATION

   a. Communication with Office staff

      i. Staff can help with the administrative aspects of our practice.

      ii. Staff can relay messages to the Clinicians (physicians, psychiatric nurse practitioners, therapists).

   b. Communication Concerning Clinical matters outside of office appointments

      i. We understand that sometimes clinical concerns happen between appointments.

      ii. In these situations, it is important to understand several things:

         1. The Clinicians in the office are attending to patient appointments and scheduled treatments throughout each day.

         2. Office staff are not clinically trained and cannot answer clinical questions.

         3. If a patient, or parent/guardian sends a message with a clinical concern, or question office staff will send the clinical concern to the primary treating clinician.

         4. Clinical concerns or questions as determined by protocol, may prompt staff to schedule an appointment for you with the primary treating clinician.

         5. Long, detailed messages to staff about your clinical concern or question cannot take the place of an appointment; these sorts of communications may prompt office staff or the clinician to schedule an appointment with the first available, or the clinician or nurse covering for the day.

         6. If your primary clinician is not available to answer the clinical concern or question, in the next 24-72 hours, office staff will attempt to schedule an appointment or phone call another clinician or nurse as soon as possible.

         7. Clinical concerns often require an assessment of the situation to make a clinical decision on your care as well as a review your medical record, a review of the controlled substance database, a review of your prescription drug history by your pharmacy benefits manager, discussion with your pharmacist, sometimes a discussion with your insurance company, discussion(s) with other healthcare clinicians involved in your care, discussion(s) with family or significant others as is allowed by privacy laws.

         8. Clinical communications such as phone calls to other healthcare clinicians, emails, phone calls, paperwork, prior authorizations, refills require time and have charges associated with them and could be covered by insurance if completed in an appointment with the patient. See Good Faith Estimate Section.

   c. HIPAA Compliant Text Line - 615-551-5853

      i. Our text line is for patients, and potential patients to communicate with staff during office hours.

      ii. Please consider text messages, like emails to our office. This is another way to communicate with staff to reschedule appointments, schedule appointments, ask a non-clinical question, etc.

iii. Clinicians may send patient information from an appointment via this secure text line 615-551-5853, i.e. directions following the visit, links for virtual visits, confirmation of refills, educational information or links. Do NOT accept any other text lines regarding care from our clinic.

iv. Text lines are a shared resource: it is important to note that private information shared via this text line is shared with all staff and clinicians in the offices. All staff and clinicians can see these communications and these communications can be included as part of the patient electronic medical record.

v. Office Staff monitor the text line. If a patient, or parent/guardian sends a message with a clinical concern, or question office staff will send the clinical concern to the primary treating clinician via the Electronic Medical Record (EMR) Portal.

vi. Clinicians do not monitor the text line. Text lines cannot be used as immediate access to a clinician.

vii. Text lines cannot take the place of a visit with a Clinician.

viii. The Text line is not for Emergencies. Emergent issues should be handled with an emergent call to the clinician on call for the day.

d. Email

i. Please understand that using email has some inherent security risks. We only use email from multiple domain names hopeforyourbrain.com, healnashville.com, insyncdirect.com, TMSworkbook.com, Cromwellmc.com. Please DO NOT accept any emails from other domains regarding care from our clinic.

ii. We use email for appointment reminders. We prefer to use the portal for administrative purposes, like billing, receipts, scheduling, and patient feedback.

iii. We have a secure email which we can encrypt content. We can use this secure email to send records to other healthcare clinicians who also have a -direct.com email.

iv. If a patient emails clinical questions, staff will direct the patient to send the concern through the portal for security reasons via a short email that states, "we have received your email, and recommend that you send messages via our secure patient portal."

v. Email should not be used for urgent or concerning clinical issues that should be properly addressed via a consultation in a same day appointment or at a minimum a scheduled phone call with a clinician in the office.

vi. While a clinician may communicate the answer via staff within business hours, generally 24 hours is necessary for them to respond to the inquiry which is given on a business day. We do not have weekend or holiday communication except in the case of emergencies. Clinicians responding to email may charge for their time, at a prorated hourly rate; this email communication with a clinician will likely be a non-insurance covered charge.

e. Telephone, Voicemail, and Fax Line

i. The primary phone line for our clinic is 615-224-9800. This line has an extension for Emergency Calls, see section 8g.

ii. This phone line has many extensions and at each office staff extension, a patient, parent/guardian, can leave a voicemail message.

iii. Leaving multiple messages just fills the voicemail and makes it hard for the staff to get to all the voicemails.

iv. The Fax line for our clinic is 615-224-9840

f. Portal

i. Patients registered in our clinic are asked to register for our electronic medical record (EMR) portal.

1. Inside the secure portal, a patient, parent or guardian, can:
    a. accessing the link for a Telemedicine/telehealth/virtual appointment,
    b. request an appointment,
    c. find important resources,
    d. see medications and refills,
    e. communicate with staff, and
    f. pay any financial obligations

2. The Patient Portal is accessed best on a Google browser.

3. If a patient sends a portal message with a non-urgent clinical concern, office staff will send the clinical concern to the clinician. While a clinician may communicate the answer via staff within the business day, generally 24-72 business hours are necessary for the clinician to respond to the inquiry. If an earlier response is needed, an appointment should be scheduled with the next available clinician team member (another clinician in the same office).

4. Clinicians responding to messages may charge for their time, at a prorated hourly rate, or per an insurance contracted rate; these communications with clinicians may be non-insurance covered charges.

5. Portal Messages do not take the place of visits, your Clinician may request the patient schedule an appointment to get information & to give the best possible care.

6. Your primary clinician's time to read, consider, and respond to your portal messages may be associated with a charge which may be covered by insurance. Many times the portal message will result in the clinician requesting that the patient schedule an appointment when the issue can be thoroughly evaluated. See Good Faith Estimate Section.

g. Emergency Communication

i. We have a 24-hour emergency call number which can reach our prescribing clinician on-call. This 24-hour emergency line is for patient's currently under our care.

ii. If a patient has an emergency and needs to speak with a clinician during or after office hours, call 615-224-9800, and listen to the prompts to be transferred to the Emergency On-Call Prescribing Clinician (physician or psychiatric nurse practitioner). The call will be transferred to this person. If the extension is reached in error, simply hang up. If you reach this Emergency On-Call Physician or Prescribing Clinician voicemail, leave them a message and they will quickly return the call. If they do not call within 10-15 minutes, please call again.

iii. Emergency charges will apply and may be billed to insurance. See the Good Faith Estimate Section.

iv. The portal, the text line, nor email are intended for emergent communication. It is best to call the On-Call Prescribing Clinician for any emergent concerns.

9. FINANCIAL POLICY - GOOD FAITH ESTIMATE OF CHARGES

a. Payment for Appointment & Services

i. Our office charges fees for the services given; we offer medical, psychiatric, psychotherapy, and mental health services to patients.

1. We do participate in clinical research studies at times. Patients who are participating in these studies will have their care costs covered by the research study. If the patient continues in our care outside of the study, those appointments will incur charges which are the patient's responsibility.

ii. Payment for patients charges takes three forms: 1) Self Pay or Private Pay, 2) Out-of-Network, or 3) In-network Insurance

iii. Regardless of insurance status, it is always the patient's or parent/guardian's obligation to pay all balances, copays, deductibles, and any co-insurances due.

iv. Insurance Companies may not cover all possible fees which may be charged to the patient, please review the non-covered charges policies to acknowledge that you understand.

v. If the patient's insurance company fails to reimburse our clinic because of any type of non-coverage for the patient, the patient, or patient's parent/guardian, will be financially responsible for all balances, copays, deductibles, and any co-insurances due. See the Non-Covered Charges Policies below for details on which charges may not be covered.

Special Note: We require that patients have a credit card on file with our office to pay outstanding charges. See Credit Card authorization below.

b. Insurance

i. Commercial Healthcare Insurance

1. The physicians, psychiatric nurse practitioners, and therapists in our offices uniquely offer quality care and are in contract with many Commercial Healthcare insurance companies to care for their patients.

2. It is important that you understand how your insurance works, who administers your health benefit, and what you will have to pay before you arrive in our offices. Call your insurance company and ask questions before you arrive to avoid unexpected issues.

ii. In-Network Contracted Healthcare Insurance

1. Most of our psychiatrists and psychiatric nurse practitioners are in-network with the following insurance companies: Aetna, Blue Cross Blue Shield, Anthem, Cigna, United, United Healthcare, OPTUM, UMR, Choice Plus, and some affiliates of these health insurance companies.

2. Some of our therapists may be in-network with insurance. Please ask if you need an in-network therapist.

a. To verify if a clinician is in-network, call your insurance plan.

b. Rarely, a patient may have an insurance card that is labeled as one of the insurance companies that a clinician is in network, but the patient's coverage is actually managed by a third party administrator or another carve-out entity for behavioral health benefits that we may not be contracted with as "in-network." If the insurance claim processes as out-of-network, the patient will be financially responsible for the out of network/self pay rate for those appointments.

c. Please investigate if you do not know if we are in-contract with your insurance company. Our website can help in this regard. Our billing team can help as well, billing@hopeforyourbrain.com.

3. Being in-network (contracted) with a commercial health insurance company allows our office to help improve access to care, and to help as many patients as we can.

4. Patients who have health insurance coverage should provide their complete and correct information so that claims can be submitted if our clinic is in-network with the insurance company.

5. When we are in-network with a patient's insurance company, we will submit (file) the office charges via an electronic claim when they are covered. In addition, when we are in-network we must obtain authorization from the patient, parent/guardian, to allow the NeuroScience & TMS Treatment Center to release all information necessary to secure the payment of benefits with insurance. If accurate commercial insurance information has been given; this information may include my diagnosis(es), past medication and past treatment for diagnosis(es) and history psychological service treatment, including copies of medical records.

6. We will collect co-insurance, copay, and deductible charges from the patient or parent/guardian, when applicable, and will then expect insurance to cover the remaining balance.

7. The insurance company will determine what they owe by discounting the charge for the service to the maximum allowable rate and to the agreed upon rate, per our office's contractual relationship, and subtracting a patient's copay, coinsurance, deductible, or non-covered charges from the charge.

8. We have contracted to accept a negotiated rate from insurance companies and can NOT further discount service to patients.

9. The insurance company will send payment and a remittance statement to you, the patient, and our office (what insurance refers to as the "provider" of service). This remittance statement is often called the Explanation of Benefits (EOB).
    a. If you do not understand your EOB, call your health insurance company.

    b. If you do not understand the charges, our billing staff can help explain.

10. Per our office policies and as agreed below, once the EOB is received in our office, we will charge the amount due to the Credit Card on file for the patient account. Outstanding copays, coinsurance, deductible, or non-covered charges will be charged to this credit card per the Credit Card authorization policy below. These charges are determined by your insurance company and by patient appointment attendance.

a. If you do not understand your EOB and are contesting the charges with your insurance company, you are still responsible for the charges in our office as determined by your healthcare insurer.

b. Our policies, communicate our non-covered charges policies which insurance does not allow. The patient or parent/guardian will be 100% responsible for those non-covered charges regardless of whether insurance allows the charge.

c. If you have a dispute with your insurance, and you resolve the issue, we can refund or credit any charges which are documented on a corrected EOB by your healthcare insurance company.

iii. Out-of-Network Insurance

1. We are not contracted with some insurance plans.

2. If we care for a patient that has insurance with which we have not contracted, charges would be considered "out-of-network" or "self pay."

3. Once the charges are paid in our office, the billing staff can provide a Statement Of Service (SOS) to the patient for reimbursement out-of-network charges.

4. We recommend that patients contact their insurance carrier and request instructions for filing out-of-network claims. It is the Patient's responsibility to obtain all referrals/authorizations required by out-of-network insurance plans.

5. Patients must follow up with their insurance to understand how out of network claims will be reimbursed. The Patient or responsible party is responsible to check with their insurance plan from time to time to ensure claims are being properly processed.

6. The patient will have to submit this form to their insurance company. We cannot do this, and do not guarantee out-of-network insurance reimbursement of any kind.

iv. Government Sponsored Healthcare Insurance: TennCare, Medicaid, and Medicare

1. If the patient qualifies for Medicaid in Tennessee, the patient may have TennCare. If the patient is disabled or over 65, the patient may have Medicare. Some patients have a form of Medicaid that fills in the gaps of coverage offered by Medicare.

2. Our clinicians do not accept these public plans: TennCare, Medicaid, nor Medicare payments.

3. We hope, by the end of 2024, to be contracted with Medicare.
    a. When we complete our Medicare contract, we will not be contracted on managed Medicare policies as the contractual rates for these plans are significantly under Medicare Rates.

    b. Carve out policies (managed Medicare) that give patient's incentives to join (gift cards and the like), pay less money to clinicians and micromanage and interfere with prescribed medical and psychiatric care with excessive prior authorizations for generic medications and standard services.

c. For these reasons (more work and less pay) we have chosen not to accept these plans in the offices. These plans name themselves: Cigna Medicare, Optum Medicare, United Behavioral Health Medicare, etc. These plans are neither a standard insurance policy nor Medicare, but an unfortunate mix of both.

d. Because we are not contracted with Public Insurance, presently we CANNOT file patient claims with Medicare, Medicaid, nor TennCare.

e. Some clinicians have special contracts with other clinics or hospitals and cannot accept patients with these insurance policies in our offices at this time.

v. Secondary Policies to Medicare

We do not accept these plans in our clinics now.

1. Some patients who have Medicare buy supplemental policies to cover expenses beyond Medicare covered charges.

2. When/if we are in-network with Medicare, we will submit claims for charges and services to Medicare, and then Medicare is responsible to send the claim to any supplemental policy for which the patient has purchased. If we are not in-network with the supplemental insurance, they may not cover any portion of the charges.

10. NON-COVERED SERVICES & APPOINTMENT CHARGES POLICY- GOOD FAITH ESTIMATE OF CHARGES

a. Non-Covered Service and Appointment Charges Policy for Emergent Call Charges

i. This section applies to Charges for Virtual visit(s), phone call(s) or face to face session(s) which were not previously scheduled but may be necessary to care for you, or those virtual visits, phone calls or face to face sessions which occur outside office hours (Emergent).

ii. Even though Emergency phone calls or virtual visits may be covered by some insurance when our clinicians are in network, healthcare benefits insurers or administrators may determine that certain service(s) may be an Investigational Service(s), may not be Covered Service(s), or may not be Medically Necessary or Medically Appropriate as those terms are defined in a patient's member healthcare insurance benefits plan. Therefore, emergency service a patient receives may be excluded from coverage by the patient healthcare benefits plan.

iii. There may be alternative treatments that may be covered by a patient's insurance company in an emergency, for instance: the patient may go to an Emergency Room or call 911 for an emergency.

iv. Our physicians or clinicians may request that insurance reconsider their determination by presenting evidence that the referenced service(s) are not Investigational Service(s), are Covered Service(s) or the service(s) are considered Medically Necessary or Medically Appropriate.

v. Patients have the right to request reconsideration of that determination, as described in the Member grievance section of the patient health care benefits plan, either before or after receiving the service(s).

vi. The potential costs of an Emergency Call to the On-Call office line with service by the on-call clinician will be charged to the patient or parent/guardian and this fee is approximately $100 per 10 minutes for a phone call or virtual appointment when completed as an emergency outside a previously scheduled appointment.

vii. The on-call clinician may be able to bill your insurance for the service, if emergency service fees are available in an insurance contract. In these cases, the on-call clinician will make an effort to bill

accordingly. In some cases, emergent or urgent charges are not covered by insurance and would therefore be patient responsibility.

b. Non-Covered Service and Appointment Charges Policy: Missed Appointments or Late Cancellations

We are committed to providing exceptional, quality health care; however, this is impossible without consistent followup visits with your clinician. Missed appointments or Late cancellations (less than 72 hrs notice) are costly to the practice and limit access to care for other patients. Appointment times are reserved for specific patients; therefore, please have the courtesy to attend your appointments as scheduled or to cancel or reschedule your appointment >72 hours prior to the appointment to avoid being charged for the appointment.

i. A late cancellation is defined as any failure to keep a scheduled appointment or to notify us to cancel with three (3) business days' notice. We have a 72-hour (three business-day) cancellation policy for all appointments; notification must be received by 4:00 pm to be counted on that business day.

ii. A missed appointment is any failure to attend a scheduled appointment. If more than half of the scheduled appointment time has passed, and you arrive for an appointment (face to face or telemedicine), the physician, psychiatric nurse practitioner, or therapist with whom you were scheduled, may define the appointment as a missed appointment because there may be insufficient remaining time to evaluate, assess, and treat.

iii. If you miss an appointment or do not cancel within the 72 hours' notice, you will be obligated to pay the full Self-Pay charge for the scheduled appointment. This cancellation policy includes telemedicine/telehealth/virtual appointments.

iv. The Missed Appointment or Late Cancellation fees are NOT billable to insurance even if we are in-network with your insurance. Your healthcare benefits insurer or administrator will determine that this appointment or service is not a Covered Services. These terms are defined in your member health care benefits plan. Therefore, the service would be excluded from coverage by my health care benefits plan.

c. Non-Covered Service and Appointment Charges Policy: Prescription Refills outside of an office visit

i. The policy in the office is to refill all medication within scheduled appointments when an assessment can be made of the patient.

ii. The prescribing clinicians (physician/psychiatrists and psychiatric nurse practitioners) in the practice, generally, do not prescribe medication outside office visits; however, if they made an error in calculation, or forgot to send something, send a portal message, text or call our office to have them correct the mistake.

iii. If you are prescribed medication, you will be given enough medication through your next scheduled appointment. If your next appointment is rescheduled because of unforeseen circumstances, contact the office staff to arrange for medication refills. We will not charge for a refill if we rescheduled and caused you to run out of medications. If you have to cancel an appointment, please reschedule quickly to avoid running out of medication.

iv. Please, DO NOT WAIT until you are out of medicine to request a refill. Contact us directly, NOT YOUR PHARMACIST/PHARMACY if you need a refill of prescribed medication, and allow 72 hours (3 business days) for a refill to be sent.

v. If you are out of medication and you are under our care, you may notify staff or the on-call prescriber. Emergency charges may apply.

vi. Medication refills are handled during office hours, during scheduled appointments, and only if you are a current patient under our care.

vii. Prescription refills outside of an office visit will be charged at the prescribing clinician's prorated charge for the time it takes to contact the pharmacy, review the file, document the refill, and if appropriate, check the State Controlled Substance database. This process can take 15 or more minutes of the prescriber's time.

viii. The standard charge for a Prescription Refill outside of an office visit is $50, the charge may be higher if multiple pharmacy changes are necessary or a significantly complicated situation occurs that is unexpected. This fee is not billable to your insurance. i. Scheduling a virtual visit or a face-to-face visit in order to get your medications refilled with a standard evaluation is the only scenario where insurance covers the charges.

d. Other Non-Covered Services and Appointment Charges Policy: Prior Authorization & Paperwork

For transparency, we want to inform you about other service or appointment charges that can occur.

i. Prior Authorization

1. If we are in-network with an insurance company you are covered by the health insurance policy and we are contractually required to obtain authorization for care (prior authorization), then we will attempt to obtain prior authorization of the planned service.

2. Prior Authorization of Services
    a. We hire staff to help manage this prior authorization process in our office, but at times, insurance reviewers deny coverage despite medically necessary care. They often note that medical psychiatric care or particular treatments don't meet their arbitrary restrictive criteria.

    b. If a patient wants to start any of treatments which need authorization before initiating treatment, a special financial agreement document will need to be completed.

3. Prior Authorization of Medication
    a. All insurance companies have different lists of covered medications.

    b. Historically generic medications have been covered by most health insurance companies and generally these companies cover the cost of generic medications at a very low copay.

    c. The real cost of these generic medications, without insurance companies is also very low. In fact, sometimes the cost of the medicine is lower than the copay with your insurance.

    d. If the physician or nurse practitioner in our office prescribes medication to you, and your pharmacist tells you that it needs a prior authorization for you to get the medication cost covered through your insurance, before your clinician begins the prior authorization process, please ask some questions to your pharmacist:

        i. Is there a generic version for this medication?

        ii. How much will the medicine cost me if it is approved by the insurance company?

iii. How much will the medicine cost me if it is not approved by the insurance company?

iv. What is the Cash Price for the medication?

v. Is there a coupon to save me money? (GoodRX, Hippo.com, or a manufacturer's coupon)

ii. Charges for Prior Authorization Process

1. If your insurance company requires a prior authorization for a medication or service which is medically necessary, there is a charge for the time to do prior authorizations. The self-pay charge for prior authorization is $50.

2. This prior authorization process could be done during a normally scheduled visit, or it can be done with the patient or parent or guardian during a new virtual appointment. These appointment charges may be billed to your, in network, insurance and still may result in a copay, coinsurance or deductible. Because of contractual relationships these charges for the time to complete the prior authorization during an appointment, may be higher or lower than $50, depending on the time that it takes to do the process.

iii. Paperwork

1. Simple forms like Work and School Excuses to document a visit in the office can be produced by staff after a visit is validated and do not cost for their production.

2. When Prescribers or therapists provide paperwork (copies of a note or discharge plan) to your other treating clinicians, they do not charge to coordinate that care.

3. The policy in the office is to charge for paperwork such as:
    a. Electronic Communications - texts or emails which were requested instead of an office visit.

    b. Insurance Appeals which are completed outside of an office visit, and which are excessive for medically necessary services which we have prescribed.

    c. Life and Disability Paperwork which is completed outside of an office visit.

    d. FMLA paperwork that is completed outside of an office visit.

    e. Long letters or summaries to collaborating care, reviewing other records, as it pertains to diagnosis and treatment.

    f. Prior Authorizations as noted above.

    g. Similar paperwork completed outside of an office visit.

4. Charges for paperwork as noted above or similar are billed clinician's prorated hourly rate. Typical paperwork charges may be $50 per 10 minutes per clinician. You may bring forms to an appointment and if there is time, your prescriber or therapist may be able to complete them in the appointment.

iv. Other Potential Non-Covered Charges: Collaborative Care and Medical Necessity Denials

1. Prescribers and Therapists may charge for collaborating care outside of your office visit, reviewing other records, as it pertains to your diagnosis and treatment; ask for these collaborations to be scheduled on the day of your visit. While this is Good Clinical Care, most insurance companies do not cover the charges to consult together.
2. An insurance plan may determine that a service(s) provided by our clinician(s) is(are) not a Covered Service, an Investigational Service, or the service is not considered to be Medically Necessary or Medically Appropriate. These are often referred to as Medical Necessity Denials. If an insurance plan makes this determination, then the Patient will be responsible to pay for all costs associated with the service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges, and any other related expenses.
3. The Patient acknowledges that his/her insurance plan may not pay for these non-covered charges or service(s) or treatment(s) and the patient would be responsible for these. Patient's have the right to request reconsideration of that determination by their insurance company, as is often described in the Member grievance section of one's health care benefits plan. If the patient wants the clinician to file an appeal or grievance, the patient may have to appoint our office as the person(s) doing this appeal or grievance.

11. PRIVACY & CONFIDENTIALITY

a. Patient privacy and confidentiality will be respected at all levels of communication and is protected by the Federal and State Laws. There are, however, situations in which confidentiality may be compromised and the provider's professional and legal duty to protect may override the dictates of confidentiality. Briefly, these situations may include a strong indication of imminent danger to self or others or indication of abuse or neglect of another.

b. RELEASE OF INFORMATION

   i. Following the execution of a valid Authorization for Release of Information, patient records, or a treatment summary will be forwarded to licensed professionals at no charge as a professional courtesy.

c. REQUEST FOR RECORDS

   i. All patients are entitled to their medical records

   ii. Requests to release mental health protected private records to any other than another healthcare office, i.e.attorneys, underwriting companies, etc. including copies to the patient themself will be billed at the actual cost of supplying the records per Tennessee Law.

   iii. This cost of records includes the cost of the clinician and staff time to review, copy, mail, and any additional professional time.

   iv. When a valid request for records is received staff will check with the Physician, nurse practitioner and any therapist who may be treating the patient to determine if the request is valid. If there are concerns, someone will reach out to the patient to verify.

      1. Any valid request for release of records must allow at least two weeks preparation time.

      2. The typical charge for a copy of a patient's medical records is $50 (*$20 charge for records and $30 for processing fee - clinician review of records to be released)*.

      3. Should the patient wish to review their entire medical record free of charge, this can be done together, in person, in an office appointment; charges for the office appointment apply.

d. PRIVACY FOR CHILDREN AND ADOLESCENTS OR ADULTS WITH A LEGAL GUARDIAN

i. Patients under the age of 18 require consent from a parent or legal guardians to receive medical services. Please discuss the concerns about the limits of confidentiality with the clinician overseeing care, and read the Privacy (HIPAA) statement on file on our portal.

ii. Children, Adolescents, and Adults with a Legal Guardian must have the guardian present for the appointments.

1. All relevant court documentation must be presented at the first appointment in our clinic (guardianship, conservatorship, or custody paperwork).

iii. With all minors, or wards, we must legally have at least one (1) parent/guardian present in the office during the first appointment, and subsequent appointments unless otherwise discussed with the clinician. The interview will include the parent for a portion of the time, but we will also take some time to see the patient alone. Any testing or available I.E.P. should be brought to the session or provided prior to the session for review.

1. If parents are divorced, both can attend if they choose; it is expected that divorced parents will maintain calm conversation focused on the patient.

2. If it is a volatile situation between parents, it is better for one (1) parent to attend and the other to write a letter describing their observations and concerns for the child. If divorced parents do not communicate well, we alternatively suggest that the non-attending parent schedule a meeting with the clinician either in-person or by phone after the initial evaluation is complete. This encounter will be billed as either a consultation with a family member or as a regular session depending on the time required and whether it is in-person or virtual. It is acceptable for the child to attend that meeting, or not.

12. CREDIT CARD AUTHORIZATION POLICY

We expect that patients will provide our clinic with a credit card number on our portal which will be kept on file with our secure vendor. This card will be used to charge any outstanding balances or non-covered charges which are incurred. We ask for a credit card authorization to cover the initial office deposit to pay for balances for appointment or service charges, copays, co-insurance, and deductibles as they occur in the course of care in our office.

While the majority of patient fees are paid for at the time of service, some charges like emergency calls, prescription refills outside an appointment, no show charges, record reviews, letters, consultations with outside providers, bounced checks, etc., as an example, may occur when the patient is not available to pay.

a. The credit card provided to our office is used to charge the initial deposit.

b. The credit card provided will be used to pay for copays, coinsurance, deductibles which are due at the time of service.

c. The credit card provided will be used per the patient, or parent/guardian's, authorization.

d. The credit card provided will be used each visit or at the time of each service for the patient.

e. Below is an authorization, alerting the person whose credit card is provided will not be notified each time the credit card is used for each service for the patient, but a receipt will be placed in the patient portal.

The following are a few examples of when charges will be applied to the credit card on-file.

i. If at the time of an appointment, we incorrectly collected a lower estimated payment (co-payment, co-insurance, and/or deductible), and then received an Explanation of Benefits (EOB)from insurance showing that we did not collect enough money from the patient (parent/guardian), then we will charge the balance due to the credit card on file.

ii. If the patient appointment goes beyond the originally booked time, the clinician may bill for the additional amount of time in the session, and this could mean that the patient/parent or guardian may have a larger charge than was expected (higher coinsurance, deductible or copayment).

iii. The clinicians may charge their hourly rate for a service on the patient's behalf (Paperwork, Review of a collaborating physician or therapist's medical records, Collaborating calls to outside clinicians caring for the patient, review of labs/tests, completing special insurance or work forms outside of visits, Urgent or emergency calls after hours, Refills outside of a scheduled appointment, late cancellations/missed appointment charges, etc).

iv. When we are in-network with the patient's insurance, we will bill insurance, for allowed charges, and bill the credit card on file for any fees due. If we overcharge, we will apply the credit to the patient's account. If preferred, notify us, and we can refund the charge.

13. SOCIAL MEDIA POLICY

a. Staff and professionals are encouraged to avoid personal virtual relationships via social media (e.g.

Facebook, Snapchat, Instagram, LinkedIn) with patients. Requests to friend a clinician will not be honored in order to respect professional boundaries.

14. TERMINATION OF CARE

    a. Our clinicians and patients may terminate services for any number of reasons. Some terminations of care, for example, are because a patient fails to pay account balances, or because of clinician and patient differences in philosophy of care. Terminations which are started by either the patient or the clinician are permanent, (patients may not return to our clinic's care), with the exception of a termination because the patient moved but then returned to Tennessee, in these cases, patients may return to our care.

15. SPECIAL LAB TESTS OR PROCEDURE RESULTS (Labs, Urine Drug Screening, Pharmacogenetic Testing)

    a. Most lab results will be reviewed with the patient at the next scheduled visit, (unless there is a more pressing need prior to the visit). A small clinical charge may be charged to review the laboratory values when the results arrive in our office.

    b. The patient will be charged based on the clinician's time utilized at the clinician's discretion per their prorated hourly charge. In most cases, clinicians will attempt to wait and review the information during the next patient appointment.

    c. In some cases, because an appointment may not be scheduled for a significant time after the lab results return, clinicians may decide to communicate the results to the patient before the next appointment. These results can be sent via email, secure text, fax, and mail.

    d. Urine Drug Screening and Pharmacogenetic Testing may be medically necessary for some patient's care or treatment in the office. Laboratory collection fees may apply if we are collecting and processing the specimen; a $30 fee to collect, process and record the laboratory results will apply.

16. CONTROLLED SUBSTANCE MEDICATIONS

    a. Medications called controlled substances are indicated in some psychiatric illnesses and may be used by a prescribing clinician at the NeuroScience & TMS Treatment Center for a patient's treatment. We have a specific Controlled Substance Agreement which a patient must sign when being prescribed a controlled substance for Attention Deficit Hyperactivity Disorder (ADHD) or other medical diagnoses which may benefit from medical treatment with these controlled medications.

    b. Shortages of controlled substance medications used for Attention Deficit disorder and other conditions do occur. This is not a problem that our office can fix. Sometimes a local and even a national shortage can occur. As we can not keep track of individual pharmacy stock and because these medications are controlled by federal and local agencies, it is best if the prescription is maintained at the pharmacy to which it was sent.

    c. We understand that it can be scary not having medication, but not having a stimulant will not cause dangerous symptoms. Pharmacists are able to transfer a controlled substance script one time if they do not have the stock.

    d. Only in dire situations will a prescriber switch pharmacies once an electronic prescription for a controlled substance is submitted to the pharmacy. Because this process of switching a controlled substance is complicated, please note that patients may incur a prescription refill outside of an office visit charge for changes to a pharmacy (up to $50). Prescribers will determine this on a case by case basis.

    e. There are effective non-controlled medications for ADHD that can be used for patients as an alternative to stimulants.

f. Controlled substances can have an increased risk of dependence and/or addiction for some people, therefore it is expected that each patient prescribed this medication will review and sign a controlled substance agreement. Patients should not vary the dosage, nor interval of these medications without authorization.

g. Failure to follow the agreement guideline, may result in my treatment being terminated.

17. DEPOSITION POLICY

    a. Please contact our office directly if a deposition is necessary. We have a specific policy on depositions for patients or former patients.

18. BILLING DISPUTE POLICY

    a. If a patient receives a charge which they believe to be invalid, our office will accept *a written notice concerning the disputed charge*. We will review the dispute with supporting evidence and respond in a timely manner. We strive to get billing correct and will work with you to understand the charges.

19. FINANCING POLICY

    a. We do not have payment plans or financing options internally. We recommend using a credit card to finance payments to us if needed.

20. INSUFFICIENT FUNDS POLICY

    a. The Patient agrees and understands that the Not Sufficient Funds (NSF) Fee ($15) will be added to the Patient's account for any "bounced" check.

21. INTEREST CHARGE POLICY

    a. The Patient agrees and understands that any outstanding balance over 60 days is subject to the highest interest rate allowed by law in the State of Tennessee.

22. OTHER POLICIES

    a. Every potential scenario can not be predicted. If a concern arises that we do not have a policy to cover, our Chief Medical Officer and the clinician involved will work together to consider all options that value both the patient and the clinician's time alike.