INTEGRATED WELLNESS AND STRATEGIES, PLLC
Amber W. Pearson, MA, LCMHC, LPC, LMHC
Your path to healing and transformational growth...
2509A Lewisville Clemmons Rd
#1033
Clemmons, NC 27012
P: 720-644-6378, F: 720-446-3520
strategiesintegrated.com

SELF-PAY CLIENT INFORMATION FORM

GENERAL CLIENT INFORMATION

Current Date:_____ Client's Nickname: _____

Legal First Name:_____ Legal Last Name_____ MI: _____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Ok to leave a voicemail @ home #? ☐ Yes ☐ No Ok to leave a voicemail @ cell #? ☐ Yes ☐ No

Date of Birth:_____ Gender Identification: ☐ Male ☐ Female ☐ Other: _____

Relationship Status (please circle all that apply):

☐ Single ☐ Married ☐ Committed Partner/Spouse ☐ Divorced ☐ Widowed

School Status (circle only one): ☐ F/T Student ☐ P/T Student ☐ Not a Student

Employment Status (circle only one): ☐ F/T Employed ☐ P/T Employed ☐ Unemployed

Clients' Employer:_____Occupation:_____

How did you hear about me?_____

Note: If this is a person, I will not contact him/her, I am only asking for tracking purposes.

SELF-PAY OPTION TYPES

As a Self-Pay client, you have two options on how to pay for sessions with Integrated Wellness and Strategies, LLC (IWS, LLC). You may either utilize IWS, LLC's:

1) **Self-Pay via Out-of-Network Option:** For clients who have Out of Network benefits through their insurance carriers and wish to utilize them, IWS, LLC will provide Superbill Receipts for each session so that the client may submit a claim to insurance for reimbursement.* The process is as follows:
    a. At the time of each session, you pay the Full Service Rate. This cost can be found in the Self-Pay Good Faith Estimate section of this form.
    b. IWS, LLC provides you with a Superbill Receipt.
    c. You utilize your insurance carrier's Out-of-Network reimbursement process to submit the Superbill to get reimbursed and/or utilize the cost of therapy towards your deductible.

2) **Self-Pay Non-Insurance Option:** You pay for each session at the time of each session without submitting anything to insurance. The cost is in determined via the Base Sliding Scale Rates Chart found in the Self-Pay Good Faith Estimate section of this form. If the Base Sliding Scale Rates do not apply to you, then you will pay the Full Service Rate.

If you have FSA or HSA benefits either can be used to pay for sessions.

*Note: IWS, LLC does *not* offer to submit forms to insurance carriers directly for clients who have an Out-of-Network insurance benefits. HIPAA regulations constrain insurance carriers from discussing a client's benefits, eligibility, or plan with an Out-of-Network provider. This complicates payments to providers and causes additional challenges that are untenable for IWS, LLC.

SELF-PAY GOOD FAITH ESTIMATE

The Full Service Rates at Integrated Wellness and Strategies, LLC for Individual Therapy sessions is $130 for 50 minutes, $140 for 60 minutes, and $170 for 90 minutes. The Full Service Rate for an initial Intake Session is $150. Please note that these fees are based only on service type. Below is the Base Sliding Scale Rates Chart based on 60 minute Individual Therapy sessions:

Base Sliding Scale Rates Chart

Total Household Income Range	Number per Household					
	1	2	3	4	5	6 +
$0 to $45,000	$105	$100	$100	$100	$100	$100
$45,000 to $50,000	$105	$105	$100	$100	$100	$100
$50,000 to $55,000	$110	$105	$105	$100	$100	$100
$55,000 to $60,000	$110	$110	$105	$105	$100	$100
$60,000 to $65,000	$115	$110	$110	$105	$105	$100
$65,000 to $70,000	$120	$115	$110	$110	$105	$105
$70,000 to $75,000	$125	$120	$115	$110	$110	$105
$75,000 to $80,000	$125	$125	$120	$115	$110	$110
$80,000 to $85,000	$130	$125	$125	$120	$115	$110
$85,000 to $100,000	$135	$130	$125	$125	$120	$115

By checking one of the following two boxes and initialing below I agree to either pay the Full Service Rate or the Base Sliding Scale Rate (based on the above Base Sliding Scale Rates Chart). I understand that if I am planning to use services of IWS, LLC via the Self-Pay Out-of-Network Option, paying the Full Service Rate is required and a Superbill will be provided for submission purposes:

☐ I agree to pay the Full Service Rate as follows:

- $140 for 60 minutes of Individual Therapy
- $150 for Intake
- $130 for 50 minutes of Individual Therapy
- $110 for 30 minutes of Individual Therapy
- $170 for 90 minutes of Individual Therapy

In utilizing the Full Service Rate, I plan to use the following Self-Pay Type:
☐ Self-Pay Out of Network Option
☐ Self-Pay Non-Insurance Option

OR

☐ I agree to utilize the Self-Pay Non-Insurance Option and to pay the following for sessions based on the Base Sliding Scale Rates Chart:

- _____ per 60 minutes of Individual Therapy from the Base Sliding Scale Rate.
- _____ per Intake (*Add $10 to the Base Sliding Scale Rate*).
- _____ per 50 minutes of Individual Therapy (*Subtract $10 from the Base Sliding Scale Rate*).
- _____ per 30 minutes of Individual Therapy (*Subtract $30 from the Base Sliding Scale Rate*).
- _____ per 90 minutes of Individual Therapy (*Add $30 to the Base Sliding Scale Rate*).

In accordance to the rate agreement above, please check and/or complete the following boxes:

☐ I recognize that it is a standard for Amber W. Pearson to meet with clients for 60 minute Individual Therapy sessions either weekly or every other week. The frequency of sessions, length of sessions, and length of treatment depends on a variety of factors (ex: presenting concerns, diagnoses, desired frequency of sessions, type of treatment being sought, etc). Depending on the amount of progress we are able to make together, Amber W. Pearson will typically meet with clients who are seeking short-term therapy for 3-6 months, and those seeking longer-term treatment, for 1-4 years (or longer) depending on their needs. Length and frequency of therapy is subject to change depending on client needs. With this understanding the following can be expected based on your chosen rate (either Full Service Rate *or* Base Sliding Scale Rate):

- If we meet once per week, the monthly cost would be _____ based on a rate of _____ per 60 minute Individual Therapy session (assuming there will be 4 sessions in a month).
- If we meet every other per week, the monthly cost would be _____ based on a rate of _____ per 60 minute Individual Therapy session (assuming there will be 2 sessions in a month).

☐ I recognize that these service fees are subject to change due to cost-of-living increases. If these fees are going to change, Integrated Wellness and Strategies, LLC will inform me at least a month prior.

☐ I understand that we will review my financial circumstances at the beginning of each year to determine whether my fee per session needs to be readjusted. Until then, these fees will remain the same.

☐ I understand that if I become insured and/or my financial circumstances change, I will notify me Amber W. Pearson within one month to assess whether adjustments need to occur. Until then, these fees will remain the same.

By signing below I certify that the information about me in this document is correct. I also provide express consent to treatment with Amber W. Pearson and Integrated Wellness and Strategies, LLC. If choosing the Self-Pay Non-Insurance Option I decline insurance benefits from my insurance carrier related to this treatment. If choosing the Self-Pay Out of Network Option, I accept that a Superbill Receipt is necessary for reimbursement purposes and I hereby authorize Integrated Wellness and Strategies, LLC, and its staff to provide this information to me in order to secure reimbursement from my insurance carrier. I also agree that I have read, understand, and consent to pay the amounts specified above, in accordance to this agreement:

_____

Client Name (printed) Client Signature Date

Disclaimer: This Self-Pay Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Self-Pay Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

Right to Dispute: If you are billed for more than this Self-Pay Good Faith Estimate, you have the right to dispute the bill. Please contact Amber W. Pearson directly if this occurs. She can be contacted via the following methods:

Phone: 720-644-6378
E-mail: amber@strategiesintegrated.com