MICHAEL T. INGRAM, JR., M.S., M.D.
BOARD CERTIFIED PSYCHIATRIST
AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

Payment Policy Agreement Form

Thank you for the opportunity to help you meet your mental health goals. This Payment Policy Agreement is designed to help Dr. Ingram provide the most efficient and reasonable health care services. Therefore, it is necessary to have a Payment Policy Agreement stating Dr. Ingram's requirements for payment for services provided to patients. Dr. Ingram should have discussed with you the following services and rates:

Initial Consultation Visit, (75 Minutes)..$500.00

Follow Up Visit, (50 Minutes)...$300.00

Follow Up Visit, (25 Minutes)...$225.00

Follow Up Visit, (15 Minutes)...$175.00

Phone Calls/Consultations...$5.00/min

<u>Unless other arrangements have been made, the rates above apply.</u>

Dr. Ingram does not accept Medicare or Medi-Cal as forms of payment (Non-Participating Provider).

For patients with PPO Insurance Plans: Dr. Ingram is considered an "Out-of-Network" Provider. Some insurance companies will pay for services from "Out-of-Network" Providers, but there is no guarantee that your insurance company will pay for services. You are responsible for paying the total amount billed, regardless of whether your insurance company pays. Furthermore, Dr. Ingram is not responsible for any communication with insurance companies. This includes, but is not limited to, generating insurance claims (except for specific insurance companies such as Cigna PPO, Aetna PPO, Blue Cross Blue Shield PPO, Anthem PPO Plans, and United Healthcare PPO Plans), disputing reimbursements, or completing prior authorization forms for medications, laboratory studies, or other diagnostic studies recommended by Dr. Ingram. You will be able to generate an insurance claim for yourself through Luminello, Inc., the electronic medical record (EMR) system used by Dr. Ingram. If needed, Luminello has a user- guide to help you generate an insurance claim that you can submit to your insurance company.

There is no guarantee that your insurance company will reimburse you for the services provided by Dr. Ingram. You will be considered a self-pay patient during the entire course of treatment with Dr. Ingram unless Dr. Ingram decides to accept your insurance plan in the future. Payment is due no later than 48 hours after your scheduled appointment. Failure to pay for services on time will result in an additional fee of $100.00 and could result in termination of care.

The rates (prices) listed above will not change for the first 12 months of treatment, which begins on the day of your initial consultation visit and ends exactly 12 months after the day of your initial consultation visit. After the initial 12 months of treatment, rates (prices) for services may increase by no more than 10% each year. Rates (prices) for services will never increase above 20% of the prices listed above. You always have the option of discontinuing treatment with Dr. Ingram at any time and he will offer you referrals upon request.

8271 Melrose Ave, Unit 110
Los Angeles, CA 90046
(213) 545 - 1901
mingram@mtipsychiatry.com

ACCEPTED METHODS OF PAYMENT

- **Venmo:** [@michael-ingram-7]
- **Zelle**
- **Check/Money Order/Cash**
- **Credit Card/Debit Card/HSA Card (Subject to an additional processing fee):** Luminello Portal
- **Luminello Portal Payments:** If you choose to pay your balance directly through the portal, an additional processing fee may apply.
- **If you are using a health savings account (HSA) or flex debit card please check with your insurance provider as many HSA accounts may not allow processing through Luminello, Venmo, PayPal, etc.**

NOTE: You can generate your own insurance claim to submit to your insurance company for reimbursement by going to "Billing" and "Create Statement". If needed, I am happy to do this for you and send to you as a PDF.

As you know, it is Dr. Ingram's policy to receive payment within 48 hours after the time of your appointment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the healthcare you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

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Credit Card/Debit Card Information

Why do I have to provide Dr. Ingram with my credit card or debit card information?

Your Credit Card or Debit Card information is kept in your secure file for the entire duration of treatment. Your credit card or debit card will only be charged for late payment fees ($100.00), cancellation fees ($100.00), or failure to make a payment. All fees listed below DO NOT INCLUDE additional credit card/debit card processing fees.

What are all the potential Fees I could incur during my treatment with Dr. Ingram?

1. **Cancellation/No Show Fee**: Not showing up to a scheduled appointment AND/OR canceling an appointment within 48 hours of your scheduled appointment are subject to a $100.00 Cancellation Fee. Repeated "No Shows" and/or last minute cancellations will result in your credit card or debit card being charged for the full price of the visit.

2. **Late Payment Fee**: Failure to make a payment within 48 hours after your scheduled appointment time will incur a Late Payment Fee of $100.00. Failure to make a payment within five (5) days after your scheduled appointment will result in your credit card or debit card being charged for the Late Payment Fee plus (+) the price of services rendered.

●●NOTE: Failure to pay after one week of payment due date may result in termination of care, referral to another physician, and payment may be sent/sold to a third party collections agency.●●

Credit Card/Debit Card Information (circle all that apply):

Credit Card   Debit Card   VISA   MASTERCARD   DISCOVER   AMERICAN EXPRESS   OTHER

If OTHER, please specify: ______________

CARD NUMBER: ______________________________   NAME ON CARD: __________________________________

EXPIRATION DATE: __________   CVV (on back of card): _________

BILLING ADDRESS: ____

By signing below, you affirm you are an authorized user of the credit card or debit card whose number, expiration date, CVV, and billing address are supplied above, and you do authorize its use for all fees incurred as outlined in this form.

____   ____________________________
Patient, Parent or Guardian Signature   Date

____
Patient Name (Please Print)

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