Wellness Consulting, INC
Lori Bergstrom, MFT
Brain Wellness Program

Patient Service Agreement and Consent Form

Wellness Consulting, Inc and Lori Bergstrom, MFT ("Provider") are pleased to provide you with personalized support and care. Please read and sign the following agreement; it lists billing, scheduling and cancellation policies and procedures. If you have any questions, please ask for clarification.

A. **Scheduling Services.** Services are scheduled emailing the provider, Lori Bergstrom MFT at WellnessConsultingCA@gmail.com. If you schedule an appointment or communicate with Provider via email, you are consenting for Provider to respond to your email utilizing the same method, even if you have not completed the email and text consent you will receive in conjunction with this Agreement.

B. **Cost of Services.** Provider's cash/uninsured rate for a 50-minute consultation**/**visit/therapy session is $175.00, or other rate as agreed between you and the provider prior to the onset of services. If you plan to use health insurance, you are responsible for the contacted rate of service set by your plan. This may require you to satisfy a deductible, or remit coinsurance or a copayment. Should your plan deny your claims for payment, you are responsible for the full payment of services.

C. **Services.** You agree to receive counseling and therapy services, known as 'Services'. You agree that you understand the risks, benefits and alternatives of receiving these Services and have had the opportunity to ask questions regarding these 'Services'.

D. **Payment Methods.** You understand and agree that payment for services shall be made prior to or at the time of service or using Alma's billing platform, or directly to the provider through other accepted methods. Provider accepts payment in the form of cash or check, or credit card. [If you will be using insurance to cover some or all of the cost of your appointment, you should call Provider ahead of your appointment to ensure your insurance is accepted, and provide your insurance card to your provider prior to your appointment. You should be prepared to pay any co-payments at the time of the appointment with either cash or check, or credit card. If Provider is out of network for your insurance, Provider will submit an out-of-network claim on your behalf, but you must be prepared to pay in full for your appointment at the time of service, with either cash or check, or credit card.

E. **Cancellation Policy.** You understand that your appointment must be canceled at least *(48) forty eight hours* in advance of your scheduled visit or you will be responsible for a $50 cancellation fee for either notifying you provider late or missing your scheduled visit.

F. **Confidentiality and Compliance.** Provider will take appropriate precautions to keep your health information confidential and to not disclose it without your consent. You are also protected under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) and any other applicable federal and state laws related to protection of patient information, including but not limited to Public Health Law § 18. There are certain exceptions to when your confidential information would not be protected—for instance, if Provider believes that you will harm yourself or another person or are neglecting or abusing a child or a vulnerable adult.

G. **Waiver of Liability.** By signing this Agreement, you agree to waive, release and discharge Provider from any and all liability, including, without limitation, any injuries that may occur during the provision of services under this Agreement.

* * *

Acknowledgement and Agreement

I, _____, have read and understand the information provided above, and understand and agree to the terms in this Agreement, including costs of Services, payment methods and cancellation policy. Any questions I had have been answered.

Patient Signature: _____

Print Name: _____

Date: _____