Blue Umbrella Psychiatry
6100 Griffin Rd. 2nd Floor
Davie, FL - 33314-4416

**2027 Blue Umbrella Psychiatry Self Pay & Insurance Coverage agreement

Blue Umbrella Psychiatry Self Pay & Insurance Coverage agreement

Blue Umbrella Psychiatry (BUP) provides psychiatric and behavioral health care to patients with and without health insurance. Although BUP participates with various insurance plans, not all providers, treatments, or types of care offered at our practice are covered by insurance or eligible for reimbursement.
Patients may receive care on a self-pay basis when they do not have active health insurance, when coverage is unavailable, or when a self-pay arrangement is otherwise permitted under applicable laws and insurance agreements.

Circumstances for Self-Pay Care

Self-pay arrangements may apply for reasons including, but not limited to:

• Uninsured Patients: Patients without active health insurance who receive psychiatric evaluations, medication management, psychotherapy, or other care.

• Provider Participation: Care provided by clinicians who are not contracted, credentialed, or participating with the patient's insurance plan.

• Registered Interns & Clinical Students: Care provided by registered mental health counseling, marriage and family therapy, or social work interns, as well as graduate-level clinical students participating in supervised training programs, including those affiliated with Nova Southeastern University.

• Noncovered Care: Treatments, evaluations, or other care excluded from the patient's insurance benefits or otherwise ineligible for reimbursement.

• Treatment Limitations: Care exceeding insurance-authorized visits, frequency, or other coverage limitations, including additional treatment sessions or accelerated treatment protocols.

• Specialized Treatments: Certain treatments, including TMS, ketamine therapy, neurofeedback, and other programs that may be offered on a self-pay basis.

• Therapy, Groups & Workshops: Individual psychotherapy, couples or family therapy, group therapy, educational workshops, and other therapeutic programs that may not be covered by insurance or may be offered on a self-pay basis.

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Insurance Coverage & Billing

By signing this Agreement, I acknowledge and understand that:

1. BUP's participation with my insurance plan, if applicable, does not guarantee coverage or reimbursement for all care.

2. Insurance coverage may depend on my specific plan, the treating provider, medical necessity, authorization requirements, and other applicable limitations.

3. If I do not have active health insurance coverage, I understand that I am responsible for the applicable self-pay charges associated with my care.

4. If I have insurance but receive care under a permitted self-pay arrangement, I understand that BUP may not submit claims to my insurance for that care.

5. Self-pay payments may not be reimbursed by my insurance company or applied toward my deductible or out-of-pocket maximum.

6. This Agreement does not override applicable insurance contracts, Medicare or Medicaid requirements, or federal or state laws.

Self-Pay Financial Responsibility

For patients receiving psychiatric evaluations, medication management, individual therapy, couples or family therapy, or other routine care on a self-pay basis:

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1. I acknowledge that I am financially responsible for the applicable self-pay charges disclosed to me before receiving care.

2. I understand that BUP maintains a separate Self-Pay Fee Schedule identifying its standard rates for routine psychiatric and therapy appointments.

3. I understand that fees may vary depending on the treating provider, appointment type, duration, and nature of the care provided. Any applicable rate will be communicated before treatment.

4. I agree to pay the applicable self-pay rate at the time of each appointment unless alternative payment arrangements have been approved by BUP.

5. I understand that missed appointments and late cancellations may result in additional charges in accordance with BUP's established financial policies.

6. I understand that changes to applicable self-pay rates will be communicated before the revised rates take effect.

7. This Agreement applies to ongoing self-pay care unless replaced or modified by a subsequent written agreement.

Specialized Treatments & Programs

I understand that certain treatments and programs, including TMS, ketamine therapy, neurofeedback, group therapy, and workshops, may require separate financial agreements outlining their specific fees, payment terms, and conditions. This Agreement does not replace those financial agreements or any required clinical informed consents. *

☐ Yes ☐ No

Good Faith Estimate & Patient Rights

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I understand that, under the federal No Surprises Act, patients who are uninsured or who are not using insurance to pay for care generally have the right to receive a written Good Faith Estimate of expected charges. *

☐ Yes ☐ No

I understand that

BUP's Self-Pay Fee Schedule provides standard appointment rates but does not replace an individualized Good Faith Estimate. *

☐ Yes ☐ No

The frequency and duration of psychiatric treatment and psychotherapy may vary based on clinical needs, treatment goals, and progress. *

☐ Yes ☐ No

A Good Faith Estimate will be provided when required by law or upon request. *

☐ Yes ☐ No

If I receive a bill that is at least $400 more than the Good Faith Estimate from a particular provider or facility, I may qualify for the federal patient-provider dispute resolution process. *

☐ Yes ☐ No

For additional information about Good Faith Estimates and patient rights, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Patient Acknowledgment & Agreement

By signing below, I acknowledge and agree that:

• I have read and understand the terms outlined in this Agreement.

• I understand that BUP provides both insurance-covered and self-pay care.

• I understand that I am financially responsible for care received under an applicable and legally permitted self-pay arrangement.

• I understand that applicable fees will be disclosed before treatment and that I may request information about my financial responsibilities.

• I have had the opportunity to ask questions regarding insurance coverage, self-pay arrangements, and billing policies.

• I voluntarily agree to the applicable financial terms outlined in this Agreement.

PATIENT/LEGAL GUARDIAN SIGNATURE _____

DATE _____

This version supersedes and replaces all prior versions of this Agreement