Family & Children's
SERVICE OF ITHACA

Prompt Pay Discount Agreement Form

Patient Legal First and Last name: _____ Preferred Name: _____

If not the patient, other responsible party for payment: _____

Address of responsible party for payment: _____

By participating in this agreement, you agree to the following terms and conditions:

1. **Eligibility:** This discount is available to patients who are not using insurance or any other third-party payers and are choosing to self-pay for their services.

2. **Discount Amount**: When all criteria of this agreement are met, you are eligible for a 48% discount on each service rendered during the effective period of this agreement. The effective period will default to one year from the date of the signature on this agreement unless otherwise noted.

3. **Billing and Payment:** All payments at the discounted rate must be made during business hours on the same day services are provided. Any services not fully paid for within this time frame will be charged at the full rate without the discount applied. If the service was rendered outside routine business hours, payment must be made the following business day. Please be aware that telehealth copays are typically not collected by the front desk on the day of your appointment. If you have a telehealth session scheduled, please contact the front desk to ensure your payment is processed on the appropriate day.

4. **Non-negotiable**: This discount rate is non-negotiable.

5. **Exclusions:** This discount does not apply to any prior balances accrued prior to this agreement being signed.

6. **No Insurance Claim:** By participating in this agreement and accepting the prompt pay discount, you agree not to submit any claims for reimbursement to your insurance provider or any other third-party payer for the services covered by this agreement.

7. **Termination of Agreement:** Should you wish to terminate this agreement and resume billing of insurance or any other third-party payers, the financially responsible party must give us written notice that they wish to end this agreement. Please note that any services received prior to that written notice will not be able to be billed to insurance and so you are responsible for all fees incurred up until that date.

By signing below, you acknowledge that you have read, understood, and agreed to the terms and conditions outlined in this Prompt Pay Discount Agreement.

Signature: _____
Date: _____

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Please return a signed copy of this agreement to our office as soon as possible. If you have any questions or require further clarification, please feel free to contact our billing department at **607-273-7494** or via email at Billing@fcsith.org.

Date of Good Faith Estimate:			
Prompt Pay Discount: 48%			
Summary of Expected Charges			
Service name	Regular Rate	Prompt Pay Discount	Prompt Pay Fee
Psychotherapy – Evaluation	$300.00	-$144.00	$156.00
Psychotherapy – 30-45 minutes (Individual patient only)	$200.00	-$96.00	$104.00
Psychotherapy – 30-45 minutes (With Family)	$250.00	-$120.00	$130.00
Psychotherapy – 45-53 minutes (Individual Patient only)	$250.00	-$120.00	$130.00
Psychotherapy – 53+ minutes (Individual or with Family)	$250.00	-$120.00	$130.00
Psychotherapy – Crisis, first 60 minutes	$350.00	-$168.00	$182.00
Psychotherapy – Crisis, each additional 30 min	$150.00	-$72.00	$78.00
Psychiatry – Diagnostic Evaluation	$300.00	-$144.00	$156.00
Psychiatry – New Patient Evaluation & Management 10 min	$50.00	-$24.00	$26.00
Psychiatry – New Patient Evaluation & Management 20 min	$75.00	-$36.00	$39.00
Psychiatry – New Patient Evaluation & Management 30 – 44 min	$150.00	-$72.00	$78.00
Psychiatry – New Patient Evaluation & Management 45 – 59 min	$240.00	-$115.20	$124.80
Psychiatry – New Patient Evaluation & Management 60 – 74 min	$250.00	-$120.00	$130.00
Psychiatry – Existing Patient Evaluation & Management 5 min	$50.00	-$24.00	$26.00
Psychiatry – Existing Patient Evaluation & Management 10 min	$75.00	-$36.00	$39.00
Psychiatry – Existing Patient Evaluation & Management 20 – 29 min	$150.00	-$72.00	$78.00
Psychiatry – Existing Patient Evaluation & Management 30 – 39 min	$240.00	-$115.20	$124.80
Psychiatry – Existing Patient Evaluation & Management 40 – 54 min	$250.00	-$120.00	$130.00
Psychiatry – Individual Psychotherapy Add-on	$125.00	-$60.00	$65.00
These are the most common services we provide, though other services are available. For a full list, please ask the billing department. Prompt pay will be charged at the rate of the service as scheduled. If there are differences between the scheduled and rendered service, the billing department will reconcile the difference and provide repayment and/or send a statement with remainder owed.			