FINANCIAL POLICY

There are two components to the provision of Transcranial Magnetic Stimulation ("TMS") therapy that are reflected in the costs to you:

1. **Initial Consultation:** Before TMS therapy is administered, you will receive an initial consultation to determine if TMS is appropriate for you. The cost of the initial consultation is **$250** and is due regardless of whether you proceed with TMS therapy.

Note: Payment is due at the time of the initial consultation.

Depending on the terms of your specific mental health insurance policy, the initial consultation may be covered by insurance, and your insurance carrier may reimburse you. As a courtesy, we can submit a claim to your insurance carrier if you would like us to do that.

2. **Transcranial Magnetic Stimulation ("TMS") therapy:** TMS therapy is provided by TMS Center of Colorado, LLC. The cost for the initial course of therapy may vary depending on the treatment protocol prescribed for you. On average, the course of treatment will range from $8,000 to $12,000 for 20-30 sessions. Additional treatments may be required for maximum benefit. **Additional treatments** are $550 for Motor Threshold Measurement and $400 per additional treatment session.

Insurance Coverage and Reimbursement for TMS Therapy: Many insurers provide coverage for TMS therapy based on specific conditions and treatment protocols. It is the patient's responsibility to contact his or her insurance company, verify benefits and determine coverage based on the patient's diagnosis and specific benefit plan. Our billing staff will assist you in submitting claims to your insurance company for reimbursement. **Please understand, however, that you are responsible for <u>all</u> charges incurred. A referral from your physician, pre-certification of insurance coverage, and recommendation for TMS therapy, among other things, do not guaranty insurance payment.**

Payment is due in full at the time of scheduling the initial course of therapy for all self-pay, out-of-network and off label care, regardless of whether we assist you in filing with your insurance carrier.

If TMS Center contracts with your insurance carrier: In the few cases where The TMS Center of Colorado has a contract with your insurance carrier, we will bill your carrier in accordance with the terms of the contract. We will collect all co-pays, co-insurance, non-covered service charges and deductibles from you at the time of service.

Denial of Coverage: If coverage of TMS therapy is denied and you would like to appeal the denial, your insurance carrier may require a letter of medical necessity. We will furnish the letter on your request. Please be aware that our charge to insurance may differ from our charge for self-pay patients. If your insurance carrier ultimately approves coverage of TMS therapy, we must collect any copayments, co-insurance and deductibles required under your insurance plan.

Payment for TMS Therapy: The patient is responsible for payment for TMS therapy (see above regarding filing for insurance reimbursement*)*. We accept most forms of payment. Payment for TMS therapy should be made to TMS Center of Colorado, LLC. Returned checks will be charged the entire amount plus a $25 return check fee.

Cancellation policy: In order for TMS Therapy to be effective, it should be performed on a routine basis for a minimum of 20 sessions/4 weeks (treatment is generally scheduled M-F). **Missing any treatments could affect your response and is not advisable. There are no refunds for missed treatments.**

We will refund payment **ONLY** if we receive notice of cancellation at least seven (7) days before the date your initial (acute phase) treatment is scheduled to begin. **No refunds** will be given after this time (seven (7) days prior to starting the initial (acute phase) treatment block).

Patient Acknowledgement:
I have read the above financial policy and have been given an opportunity to ask questions and my questions have been answered to my satisfaction. A copy of this form has been made available to me.

Patient Name: _____ (print)

Patient or Guardian's signature: _____

Date: _____