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## ADDENDUM TO CLIENT SERVICES AGREEMENT

### Private Contract with Alvord, Baker & Associates, LLC, a Non-Participating Provider

Alvord, Baker & Associates, LLC has developed this addendum agreement to inform you of our policy with regard to health insurance coverage. If you choose to seek services with Alvord, Baker & Associates, LLC, it is important that you understand our policy and recognize that you are entering into a private contract, which may be outside the context of your insurance plan.

#### What this may mean to you:

**Alvord, Baker & Associates, LLC does not participate with insurance carriers, and we do not accept the checks written directly from them.**

Certain insurance plans, including HMOs, will allow you to see out-of-network providers and will only release reimbursement checks directly to the provider. In such cases, our policy is to return these checks to the insurance carriers. If we, Alvord, Baker & Associates, LLC, accepted an insurance carrier's checks, we may implicitly be required to follow the insurance company's recommendations for treatment and fees for service and this may differ from our standard of practice.

Another possible situation is that some HMO policies only permit clients to see out-of-network providers *if the client agrees not to utilize their HMO mental health benefits*. This means that if you see an out-of-network provider, you are agreeing to forfeit your right to submit your invoices and you are unlikely to receive any reimbursement for the services provided.

**We encourage you to contact your insurance carrier and obtain a clear understanding of your mental health benefits. There are many mental health plans and they differ widely.**

#### SUMMARY:

I, \_\_\_\_\_, am entering a private contract with  
(Client's Name)  
Alvord, Baker & Associates, LLC and

- I understand that Alvord, Baker & Associates **does not participate with any insurance carriers.**

- I understand that Alvord, Baker & Associates **does not accept clients who have Medicare insurance.**
- I understand that Alvord, Baker & Associates, LLC **will not accept any payments sent directly to them by my insurance company.** Our standard policy is to return the check to the insurance company to re-issue to the subscriber. **However, if my insurance carrier will only release payments to Alvord, Baker & Associates, LLC, I may not receive any reimbursement for the services provided.**
- Depending on my insurance plan (for example, Tri-Care), I understand that I **may be denied reimbursement, even for the “allowable” amount permitted.** I may also be forfeiting my right to submit a claim for services received at Alvord, Baker & Associates, LLC and if I submit a claim, I may not receive any reimbursement from my insurance carrier for services provided. (I understand that Tri-Care and possibly other insurance providers will deny reimbursement for our services.) My signature below also serves as my consent to **waive any balance-billing protection** for any and all services provided by Alvord, Baker & Associates, LLC. These services may include, but are not limited to, the following procedure codes: 90871 (intake), 90834 (individual therapy), 90846 (collateral therapy), 90853 (group therapy), (family therapy), 96101 and 96103 (psychological testing), as well as others, at the rates currently charged for these services. These services may include, but are not limited to, the aforementioned procedure codes.
- I agree that I am solely responsible for payment to Alvord, Baker & Associates, LLC, and if I have a conflict with my insurance carrier, it is my responsibility to resolve it directly with my carrier.
- I agree that I will not hold Alvord, Baker & Associates, LLC responsible for any disputes that arise between my insurance carrier and myself.

\_\_\_\_\_  
Responsible Financial Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Financial Party Name Printed

\_\_\_\_\_  
Responsible Financial Party #2 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Financial Party Name #2 Printed

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name Printed