

**ATM Mental Well-Being, LLC**
Phone/Text: (913) 674-3766
Fax: (913) 674-3774
Website: atmmentalwellbeing.com

**Patient Services Agreement**

## 1. Services Provided

**ATM Mental Well-Being, LLC** offers psychiatric mental health evaluation, diagnosis, medication management, and supportive therapy services via telehealth.

## 2. Fees and Payment Policy

• Session Fees: The full session fee is due by the time of the scheduled appointment.
• Sliding Scale: A sliding scale option is available. Minimum payment is 50% of the full session fee.
• Initial/Intake Appointment: 60-75 minutes; $350-$400

• Follow-up Appointment: 30-45 minutes; $175-$200
• Payment Methods: Payments via credit/debit card, HSA, or approved online systems.
• Late Payments: Must be resolved before the next appointment. Chronic non-payment may result in discharge.

## 3. Missed Appointments & No-Show Policy

• Cancel at least 24 hours in advance.
• No-Show Fee: $75
• Late Cancellation Fee: $50 (unless emergency)

## 4. Communication Policy

• Secure messaging is for non-urgent communication via the patient portal.
• Allow up to 3 business days for response.
• Call 911 for emergencies.

## 5. Medication Refills

• Refills are provided during scheduled appointments.
• Refill requests outside of sessions may take up to 3 business days.

## 6. Confidentiality

All information is protected under HIPAA. Information is only released with written consent or as required by law.

## 7. Termination of Services

Services may be terminated due to non-payment, missed appointments, or inappropriate, disrespectful behavior.

## 8. Telehealth Acknowledgment

You consent to receive psychiatric services via telehealth and agree to ensure a private, secure setting. If any third parties (e.g., family members, relatives, friends) are to be involved in treatment or communication, a signed consent form must be completed prior to their participation or disclosure of any information.

**ATM Mental Well-Being, LLC** maintains a respectful, professional therapeutic environment. Disrespectful, threatening, or disruptive behavior from patients or third parties will not be tolerated and may result in termination of services.

## 9. Consent and Acknowledgment

By signing below, you are acknowledging and agreeing to the policies above and consent to treatment.

## 10. Insurance Disclaimer

**ATM Mental Well-Being, LLC** does not contract with insurance and does not bill directly. Superbills available upon request.

## 11. Good Faith Estimate Notice

You have the right to receive a Good Faith Estimate of expected charges. This is available upon scheduling or request.

## 12. Technology Requirements & Troubleshooting

A private internet connection and functioning video/audio-capable device are required for telehealth sessions.

## 13. Professional Boundaries & Scope of Practice

We do not provide emergency services, legal evaluations, or disability assessments unless agreed upon.

## 14. Records Requests

Records requests may take up to 7 business days and may incur a nominal fee depending on complexity.

## 15. Forms, Letters, and Documentation Requests

• Short-Term Disability Forms: $75 (flat rate)
• FMLA Forms: $125 (flat rate)
• Additional Letters/Narratives: $50–$100
• Updates/Revisions: $25–$50
Fees are due before completion. Form completion is based on clinical judgment and not guaranteed.

## 16. Financial Responsibility Acknowledgment

The patient agrees to be financially responsible for all services rendered by **ATM Mental Well-Being, LLC**, regardless of insurance coverage or reimbursement outcomes.

## 17. Late Arrival Policy

Patients arriving more than 15 minutes late to their scheduled appointment may forfeit their session and be subject to the standard no-show fee.

## 18. Risks of Electronic Communication

While **ATM Mental Well-Being, LLC** uses secure platforms to conduct telehealth and communication, no system is completely secure. By using electronic communication, the patient acknowledges and accepts these risks.

## 19. Governing Law and Dispute Resolution

This agreement shall be governed by the laws of the state of Kansas. In the event of a dispute, both parties agree to pursue informal resolution or mediation prior to any legal action.

**20. Patient Services Agreement Submission**

Please submit your completed and signed Patient Services Agreement to: **pmhnpATM@atmmentalwellbeing.com**.

**Note:** This email address is used **for administrative purposes only**. For all clinical questions, concerns, or appointment-related inquiries, please use your secure patient portal to ensure timely and confidential communication.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third-Party (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_