iTrust Ψ Wellness Group

Psychiatric Prescribing Providers

To our valued clients and their families,

It is our privilege to be able to offer mental healthcare for you or your loved one. We understand the vulnerable and sometimes desperate position patients and families are in as they seek mental health treatment. At iTrust Wellness Group, we look beyond the surface to assess each client's unique situation, giving a holistic approach to senior mental health care. Services that we offer include both medication management and talk therapy. Our providers are specifically trained and are specialists in the mind and mental health.

While our services are not included in the overall cost of the facility, our company believes in transparency when it comes to medical billing. For this reason, we have a very straight forward billing process. When a patient enrolls for our services, he or she will receive therapy and medication management services every two weeks for an out of pocket cost of **no more than $29.99 per month**. iTrust Wellness Group will bill the patient's insurance as normal but will discount any outstanding financial responsibility above and beyond this amount. In this way, our patients and their families know that they can receive high quality, trusted, and specialty care in the home setting without wondering about any additional financial burden from our medical services.

In these difficult times, iTrust Wellness Group is prepared to help. We strongly believe that mental healthcare is just as important as physical healthcare. If you would like to receive a 'mental health checkup' or have questions about certain emotions or behaviors that you may be experiencing or feeling, please enroll today and speak to one of our providers.

In solidarity,

Steven Krozer, iTrust Wellness Group CEO and Psychiatric Nurse Practitioner

iTrust Ψ Wellness Group

Psychiatric Prescribing Providers

Please complete the information on this form and sign where appropriate to enroll into care with our mental health specialist. Filling out the form in its entirety will help our staff better coordinate care. A patient care representative will reach out if any additional information is needed.

Patient Information

Patient Name:	Social Security Number
Date of Birth:	Street Address:
Home Phone:	City, State, Zip Code:
Mobile Phone:	Gender:

Responsible Party Information

The "Responsible Party" is the person who handles the finances for the patient (if this person is the same as the patient, leave blank)

Responsible Party:	Home Phone:
Mobile Phone:	Street Address:
City, State:	Zip Code:
Relationship to Patient:	

Preferred Method of Payment:

☐ Payment by credit card: Our office staff will run the $29.99 flat fee for services to the card on file.

☐ Payment by credit card: Our office staff will run the $29.99 flat fee for services to the card on file.

☐ Payment by checking account: Our office staff will draft $29.99 from the checking account monthly.

Please fill out the appropriate information for billing purposes depending on your preferred payment method.

Debit / Credit Card Information

Name on Card:	Card Number:
Expiration Date:	CVV:
Billing Zip Code:	Day of Month to Run Payment:
Signature:	

ACH (Checking Account Auto-Payment)

Name of Financial Institution:	
Signature of Account Holder / PoA:	Date:
Name (Please Print):	
Address (Please Print):	
Financial Institution Routing Number:	
Financial Institution Account Number:	

CONSENT FOR TREATMENT AND PAYMENT AUTHORIZATION

I consent to the evaluation and treatment of the above named patient. I also understand that I am the patient or a responsible party or power of attorney of the patient.

I hereby authorize my agents, successors, or assignees to pay the resulting amount due from any services rendered in full directly to iTrust Wellness Group, LLC from any insurance, settlement, or recovery in any way coming as a result of treatment of the above named patient. Furthermore, I agree to immediately remit to iTrust Wellness Group, LLC any payments that I receive directly from any source for the services provided to the above named patient or on any balance for which I am responsible.

I request that payment of authorized Medicare, Medicaid, Tricare, Third Party, or Liability benefits be made on the patient's behalf to iTrust Wellness Group, LLC for any services furnished to the above named patient by this provider. I authorize any holder of medical or financial information to release such medical or financial information to iTrust Wellness Group, LLC if needed to determine any benefits payable for related services. I also understand and authorize that iTrust Wellness Group, LLC nurse practitioners/psychiatrists, physician's assistants are able to make and bill for rendered services.

Print Name: _____ **Date: _____**

Signature: _____

When form is completed, please send us the form in one of the following ways:

1. Scan and e-mail to our office staff at ashley@itrustwellnessgroup.com
2. Fax to (864) 640-4400

Please call us at (864) 520-2020 if you have any additional questions!