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**Anthony Centore Ph.D.**  
President

Provider Medical Billing Sign-up and Welcome Packet

Dear Provider,

Thank you for your interest in Thriveworks Medical Billing. We are delighted to provide you with the enclosed information.

Thriveworks provides professional, full-service, medical billing. We offer electronic insurance billing, full-service patient billing, authorization obtaining and checking, insurance carrier follow-up, and much more. We are fully committed to providing our clients with low cost, accurate services, no matter how large or small your needs.

Please review the enclosed information at your leisure. Should you have any additional questions, please do not hesitate to contact us at any time.

We look forward to working with you!

Warmly,

Anthony Centore Ph.D.



Proud to be accredited by the Better Business Bureau



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## Getting Started

Signing on with Thriveworks Medical Billing is quick and easy! For your convenience, we have provided the checklist below.

### CHECKLIST FOR GETTING STARTED

- Review and sign the *Thriveworks Service Agreement*.
- Complete the *Practice Profile Page*, which will provide us with your practice location and contact information.
- Complete a *Provider Profile Page* for each provider in your practice (This form is required, even if you are a sole practitioner). This page provides us with necessary identification numbers, such as insurance company PIN numbers, Tax IDs, NPIs, etc.
- Return all original forms to the address below (email, mail, or fax!).

**Once we have the above documentation, we can begin processing your claims immediately!**

### CLAIM-SPECIFIC DOCUMENTATION REQUIRED

Once you have completed the start-up forms, you can start sending us your claims! You can either use the *Thriveworks Claim Templates* provided in this document, or forms currently in-use at your office.

If you are using the Thriveworks forms, please provide us with:

- A completed *Face Sheet* for each patient or client.
- A completed *Day Sheet*. Note that only the first 3 columns on this form are required. The Dx column only needs to be filled in if the diagnosis has changed. All of the remaining columns are provided for your convenience.
- A list of your *usual and customary fees*.

If you are using your own forms, please provide us with:

- Your Superbill, or other *form(s) used in your office*. Also, please note your *usual and customary fees*.

***Thank you!***



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## Service Agreement

This Service Agreement ("Agreement") is entered into on \_\_\_\_\_, by and between Thriveworks (Thrive Counseling LLC), a Massachusetts Corporation ("THRIVEWORKS") and \_\_\_\_\_, with a principal place of business at \_\_\_\_\_ ("Provider").

WHEREAS, THRIVEWORKS offers, among other services, the processing of medical and/or dental claims electronically for Provider, and whereas Provider is desirous of using the services provided by THRIVEWORKS,

NOW THEREFORE, in consideration of the undertaking of a general course of dealings, the mutual promises herein, and other good and valuable consideration, the receipt of and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

- 1. Services.** Subject to the terms of this Agreement, THRIVEWORKS agrees, as requested by Provider from time to time, to process and electronically submit Health Care Provider's claims ("Claims") to the insurer(s) of Provider's individual patients and perform such other related services as listed in the attached "Fee Schedule" (individually and collectively "Services"). "Process and/or submission of Claims" by THRIVEWORKS does not include benefit/eligibility or pre-certification services, unless otherwise agreed upon by THRIVEWORKS and Provider. THRIVEWORKS agrees to submit respective Claims herein only after the editing and error correction of such Claim(s) by THRIVEWORKS or a competent clearing house. Provider will submit all data or other information related to the submission of Claims hereunder, to THRIVEWORKS, in the form of a superbill, daysheet, secure website, or other mutually agreed upon method by both parties. THRIVEWORKS will process and submit Claims after receipt from Provider. Provider understands that Claims received from Provider containing errors must be referred back to Provider for correction. Provider further understands that Provider is fully responsible for reviewing monthly Analysis of Services Reports to ensure THRIVEWORKS has received all claims sent, and when necessary, notify THRIVEWORKS of outstanding claims in a timely manner. All other Services will be performed on a schedule mutually agreeable to the parties. Once THRIVEWORKS undertakes the performance of a Service, evidenced by THRIVEWORKS's receipt of an order or similar request or submittal of information by Provider ("Order"), Provider may not cancel such order unless the completion of such Service(s) is unreasonably delayed by THRIVEWORKS through no fault of Provider. THRIVEWORKS agrees to maintain a high professional standard in the execution of the Services including regularly backing up all Provider-related data files.
- 2. Fees.** Provider shall pay to THRIVEWORKS, for the Services, as set forth in the Fee Schedule ("Fees"). THRIVEWORKS reserves the right to modify the Fees contained in the Fee Schedule with thirty (30) days prior written notification to Provider. Provider shall pay a monthly minimum fee of \$99. Minimum fee continues to apply for 30 days beyond date provider cancels contract. If Provider fails to provide 30 days written notice to THRIVEWORKS, \$99 per month will be assessed each month until 30 days after contract is cancelled. The attached Fee Schedule and its future modifications are incorporated and made a part of this Agreement as if set forth herein. Provider has chosen the Thriveworks Full Service Billing plan the agreed upon fee of 8% of all payments entered.
- 3. Additional Services.** If the parties agree that THRIVEWORKS shall perform additional, related services not specifically set forth in this Agreement or the Fee Schedule, such additional services shall be identified in a writing signed by both parties, stating the Fees for such additional related service(s). Such writing shall constitute a valid amendment to this Agreement and the Fee Schedule. The service(s) identified therein shall constitute "Services" as defined in, and subject to, this Agreement.
- 4. Payment Terms.** THRIVEWORKS will automatically charge Provider's credit card for due service fees on a monthly basis. If a credit card is unavailable, THRIVEWORKS will invoice Health Care Provider for all Services performed during the preceding billing period on a monthly basis. If invoiced, Payment is due within fifteen (15) days following the date of such invoice. Invoices unpaid by the due date will be subject to a monthly late fee of \$20, and/or late charges of 1.5% per month. THRIVEWORKS reserves the right to withhold the performance of Services if any amount owed to THRIVEWORKS by Provider, for any Services hereunder, is outstanding 15 days or more from the respective invoice due date(s). THRIVEWORKS may withhold or cancel such Services until such outstanding invoices are paid in full, and such withholding of Services shall not constitute a breach of this Agreement by THRIVEWORKS.
- 5. Patient Information.** Provider will not release Claim information or data, for process by THRIVEWORKS, without the respective patient/client's written consent of authorization for release of such information. Provider further agrees to maintain copies of all patient information supplied to THRIVEWORKS so that, at no time, will THRIVEWORKS process data that is not simultaneously maintained in Provider's own office. THRIVEWORKS has no liability to Provider if data or records are destroyed by fire, strike, theft, acts of God or any other cause, including computer malfunction. Provider agrees that all information supplied to THRIVEWORKS is true and accurate to the best of Provider's knowledge.
- 6. Warranty.** THRIVEWORKS warrants to Provider that it shall re-submit, at THRIVEWORKS's own expense, any inaccurate Claims submitted to patient insurers, provided that said inaccuracies were the sole result of THRIVEWORKS's performance and not due to the acts or omissions of Provider. Provider agrees that the foregoing limited warranty is the only warranty made with



Service Agreement

respect to the services, and sets forth provider’s only rights and THRIVEWORKS’s only responsibilities thereunder.

- 7. Limitation of Liability. THRIVEWORKS’s liability to Provider and/or any third party, arising in connection with the Services, shall be limited to the amount owed or received by THRIVEWORKS from Provider for the Service giving rise to the real or alleged liability. In no event shall THRIVEWORKS be liable for any rejection of claim, failure of coverage of claim, delay in payment of claim, non-payment of claim, claims denied for timely filing, loss of profits owed by Providers’ patients/clients, loss of profits owed on statements, loss of profits, loss due to delay in performance, or special, indirect, punitive, incidental consequential, or any and all other damages, arising from the provision of the Services hereunder, even if THRIVEWORKS has been advised of the possibility of such damages. Provider will indemnify THRIVEWORKS and hold it harmless with respect to all claims and liabilities, and defense of such claims or liabilities, including attorneys’ fees, arising in connection with the Services in excess of the limitation of liability set forth in this section, or arising from Provider’s failure to comply with the terms of section 5 of this Agreement. It is understood and agreed that the current and future Fees, herein, are negotiated based in part upon the allocation of risk between the parties contained in this clause.
8. Termination. This Agreement may be terminated by either party with thirty (30) days prior written notice to the other. If Provider fails to provide 30 days written notice to THRIVEWORKS, \$99 monthly minimum fee will still be assessed until 30 days after contract is cancelled. Without limiting THRIVEWORKS’s rights under section 4, THRIVEWORKS may terminate this Agreement or suspend service, if Provider fails to make payment of any invoice within fifteen (15) days of the due date of such invoice.
9. Confidentiality. THRIVEWORKS understands that any patient information received from Provider is confidential, and agrees to maintain such information in the strictest confidence, and use such information solely for the provision of Services to Provider and as is necessary for THRIVEWORKS to maintain accurate and complete records. Provider acknowledges that THRIVEWORKS may retain the services of a clearing house and/or other professional entity reasonably necessary for the provision of the Services and hereby consents to THRIVEWORKS’s transmission and disclosure of patient and/or confidential information of Provider’s expressly for such purpose.
10. General: (i) Except as otherwise expressly agreed, this Agreement sets forth the entire agreement of the parties with respect to the Services and supersedes all prior written and oral discussions. It may only be modified or waived by a writing signed on behalf of the party against whom such waiver or modifications is to be enforced. (ii) This Agreement shall be governed by and construed in accordance with the laws of The Commonwealth of Massachusetts, without regard to principles of conflicts of laws. (iii) If any part of this Agreement is found to be unenforceable by a court of competent jurisdiction or other validly empowered tribunal, the remaining provisions shall not be affected, and this Agreement shall be deemed modified to the extent necessary to enforce, as fully as possible, its provisions as written. (iv)The headings in this Agreement are included only for convenience and shall not affect the meaning or interpretation of this Agreement. (v.) This Agreement shall be binding upon and its benefits shall inure to the affiliate entities, successors and assigns of each party.

Credit Card Authorization

I authorize Thrive Counseling LLC to charge my credit card when applicable, as detailed in this agreement.

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration Date: \_\_\_\_\_ / \_\_\_\_\_

3 or 4 Digit Security Number: (\_\_\_\_\_)

IN WITNESS WHEREOF, and intending to be bound, the parties have executed and delivered this Agreement as of the month and day fir written above.

PROVIDER

THRIVEWORKS

By: [Print Name/Title] Date

By: [Print Name/Title] Date

By: [Signature] Date

By: [Signature] Date



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## 2011 Rate Card

### **THRIVEWORKS FULL SERVICE BILLING PLAN -**

Thriveworks Billing manages all receivables and monitors outstanding claims.

- Free remote access that will allow you to enter your encounters on-line in real time. Or, simply fax us your Encounter Forms and Daysheets!
- Electronic Remittance Advice. We will electronically capture your EOBs eliminating the need in many cases for you to do so!
- Track all amounts owed by patients, including co-payments, deductibles, etc.
- Comprehensive financial reports, including Accounts Receivable, Patient Payments, and Reimbursement Analysis!
- Provide complete insurance eligibility checks for any patient new to your office upon your request.
- Authorization tracking - Thriveworks will track the authorizations you obtain and provide a comprehensive report showing how many sessions are left. Provider must provide auth/referral info to Thriveworks for us to properly provide this service
- Patient interface - Thriveworks will field questions from your patients on an as-needed basis

**Fee: 8% of all monies collected/entered** (available to all Providers)

X \_\_\_ (Initial here if choosing our Full Service Billing Plan AND if you have read the Other Fees section below)

A) \_\_\_ Initial here if you would like Thriveworks to post your patient copays and balance-bill patients (see Patient Billing section below)

B) \_\_\_ Initial here if you will manage your patient balances

### **PATIENT BILLING (YOU MUST INITIAL "A" OR "B" ABOVE)**

THRIVEWORKS gives providers the option of managing their own patient billing. If you opt to do this, you do not need to inform THRIVEWORKS of any patient payments made at time of service, and therefore, THRIVEWORKS will not input copays made, nor balance-bill your patients.

If Thriveworks will manage your patient billing, we will input any payments made at time of session, and later balance-bill patients for copay discrepancies, deductibles, etc automatically approximately monthly with payments sent directly to your office. Note: the same 8% fee applies to any patient payment we enter, including amounts paid at time of service. Please note these payments on your log sheets and/or fax us payment stubs so we may properly credit the patient for all payments they make.

### **OTHER FEES & ADD-ON SERVICES**

- Provider account setup: FREE
- Specialized services (such as address changes, or research on old claims submitted by another agent, etc): \$75 per hour
- Monthly Minimum Charge: \$99



Practice/Location Profile (Please complete one form per location and return to Thriveworks - FAX: 617-395-5806)

### Location Information

Office Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Number of Physicians in Practice/Group: \_\_\_\_\_

Number of Mid-levels in Practice/Group: \_\_\_\_\_

### Practice Management Contact Information

Main Phone #: \_\_\_\_\_ Main Fax #: \_\_\_\_\_

Contact Person for Implementation/Training: \_\_\_\_\_ Email: \_\_\_\_\_

Claim Submission Setup Contact (if different from above): \_\_\_\_\_ Email: \_\_\_\_\_

Are your claims currently being transmitted electronically by another Billing Agency? If so which Agency?

\_\_\_\_\_

How did you hear about Thriveworks Billing?

\_\_\_\_\_

### EMR/MR Contact Information

Name and Telephone # of person in charge of Medical Records:

\_\_\_\_\_ Telephone # \_\_\_\_\_

How many requests for medical records do you receive? # \_\_\_\_\_ (Circle One: Daily / Weekly / Monthly)



Provider Profile (Please prepare a separate form for each provider, and return each form to Thriveworks)

**Provider Information**

Provider Name: \_\_\_\_\_  
 Office Street Address: \_\_\_\_\_  
 Office City, State, Zip: \_\_\_\_\_  
 Billing/Remittance Address: \_\_\_\_\_  
 Billing/Remittance City, State, Zip: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Provider Pager/Cell number: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ Taxonomy Number: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ www.wpc-edi.com/codes/codes.asp  
 UPIN: \_\_\_\_\_ CLIA: \_\_\_\_\_  
 State License Number: \_\_\_\_\_ Date-of-Birth: \_\_\_\_\_

Check the ID that we should use to bill your insurance carriers. Please note any exceptions, such as “Tax ID is used to submit to all carriers, except Medicare where I am credentialed under my SSN”

- Tax ID Number
- Social Security Number

**Electronic Claim Agreement Information**

If you were previously/currently setup for electronic claims transmission please contact our office. In order to enable us to initiate your payor agreements, please include the provider identification numbers for each carrier listed, as well as those for any other carriers requiring an agreement for electronic claims transmission. Please include any group numbers as well as individual provider numbers. Invalid provider IDs will delay your ability to send claims electronically and result in denials from the carrier.

Carrier:	Fill In Provider Identification Number (PIN):	Fill In Group PIN (if applicable):	Check <input type="checkbox"/> if credentialed under Indiv NPI	Check <input type="checkbox"/> if credentialed under Group NPI	Website Username	Website Password
Medicare:					N/A	N/A
Blue Cross:						
Medicaid:						
Humana:						
Aetna:						
United/UBH:						
Tri-care:						
Cigna/CBH:						
Others:						



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Name of office: \_\_\_\_\_

Physical street address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Clinic phone: \_\_\_\_\_

Fax number: \_\_\_\_\_

Office Key# if Known: \_\_\_\_\_

**Billing/remit address:** \_\_\_\_\_

City, State, Zip: \_\_\_\_\_



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Patient/Client Face Sheet

New Client     Change of Client Info-Effective \_\_\_\_\_    **Provider:** \_\_\_\_\_

**Personal Information**

Patient/Client Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email Address \_\_\_\_\_  
Date-of-birth \_\_\_\_\_  
Sex (Male/Female) \_\_\_\_\_

**Health Insurance Information**

Insurance Company \_\_\_\_\_  
Identification # \_\_\_\_\_  
Referring Provider \_\_\_\_\_  
Referring Provider NPI # \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_  
Policy Holder DOB \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Group # \_\_\_\_\_  
Secondary Insurance Co \_\_\_\_\_  
Secondary Insur. ID# \_\_\_\_\_  
Pre-certification # \_\_\_\_\_  
# of Sessions Pre-certified \_\_\_\_\_





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### Referral Credit for Colleagues

Were you referred to Thriveworks Billing by a Thriveworks client? Chances are, you were, as much of our business comes from word-of-mouth referrals. If so, we'd like to thank them with a \$50 referral credit. Simply fill in the below form and send it back to us.

Your Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

### Refer a Colleague

Do you have a colleague who could benefit from our services? If so, we'd love to get in touch with them. As a way to say "thank you!" we offer providers a \$50 bonus for every colleague referred to us, who then becomes a Thriveworks billing client.

Your Name: \_\_\_\_\_

I am Referring:

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

\* Bonus will be issued upon completion of the new client set-up. If the new client was referred by more than one party, the \$50 discount can be split between referring parties.

