INSURANCE, BILLING AND COLLECTION POLICIES:

All copayments, coinsurance and deductibles and any outstanding balances are due at the time of service.

We ask that at each visit you bring your insurance card and driver license or identification card. We only verify eligibility and not benefits.

All of our doctors are on different insurance plans. Please verify individual doctor participation status for insurance coverage.

Please be aware that your MENTAL HEALTH COVERAGE AND BENEFITS may differ from your medical. You are advised to verify your coverage. . Some may need **PRE-AUTHORIZATION. Please check with your insurance company regarding pre-authorization.**

MISSED APPOINTMENT POLICY: A minimum of $50 or a fee up to the amount of the scheduled visit will be charged for appointments missed.

We require **24 HOUR IN ADVANCE CANCELLATION NOTICE.** Insurance companies do not reimburse for missed appointments fees. You will have to pay this out-of-pocket.

ELECTROCARDIOGRAM (EKG): The patient will be responsible for the cost of the EKG in the event it is not a covered benefit by the patient's insurance. The self-pay rate for the EKG is $40. You will be responsible for any balance not covered by your insurance plan.

We are not responsible for any lab work (blood, urine) charges incurred. You may be billed separately by LabCorp/Solstas. It is your responsibility to provide insurance information to LabCorp/ Solstas.

COLLECTION POLICY: In the event that the patient does not pay in full at the time of service or neglects to pay co-payments, the patient is required to pay all past balances at the next scheduled appointment. Any Balances that age past 90 days will automatically transfer to a collection agency. We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, and/or terminate you as a patient of this practice.

AFTER HOURS PHONE CALLS: There will be a minimum fee of $25 for after hours' phone calls lasting more than five (5) minutes that are therapy related. It is at the provider's digression as to what fee will be assessed. Your insurance will not be billed for this service. You will be responsible for payment.

INSURANCE, BILLING AND COLLECTION POLICIES continued:

PRESCRIPTION REFILLS: Please allow three (3) business days to process your prescription refill. DO NOT WAIT UNTIL YOUR MEDICATION HAS RUN OUT. There are charges for any emergency refills. All prescriptions that are mailed to you will require a prepaid postage envelope mailed to the office in order to receive your prescription. Urgent refill requests will be subject to charge.

FORMS AND LETTERS: There will be a fee of $20 to complete any forms. These forms include, but are not limited to: Disability Forms, Medical Records, forms your provider is required to take time to fill out. Payment must be made in advance.

SERVICES RENDERED TO MINOR PATIENTS: The individual who initiates services for a minor is responsible for assuring payment is made at the time of service and for notifying the party responsible for medical bills of the upcoming charges.

PHONE CONSULTATIONS: Phone consultations will be billed as deemed necessary by the provider. The first ten minutes will be billed at the rate of $30. Each ten minutes thereafter will be subject to additional charges. These charges are not covered by insurance and will be billed directly to the patient. A fee of $25 will be assessed for non-emergency calls made to the on call provider during after hours, weekends and holidays.

RETURNED CHECKS: A fee of $40.00 will be added to your balance for returned checks.

MEDICAL RECORDS: There will be a minimum fee of $10.00 for any medical records requested by the patient or the patient's designated representative.

Signature: I understand that I am legally responsible for my entire bill.

Patient or Parent/Guardian Signature: _____

Print: _____ Date: _____

For Office Use Only:
I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.

Witness Signature: _____ Date: _____