

INSURANCE, BILLING AND COLLECTION POLICIES:

All copayments, coinsurance and deductibles and any outstanding balances are due at the time of service. As a courtesy to our patients, and as time allows, we will verify benefits. In order to do so, we request a copy of your insurance card before your visit. The information we receive is not a guarantee of payment, benefit or claim. We recommend that you reference your benefit booklet or consult with your insurance company.

Participating Insurances:

- BCBS-Most PPO's
- Out-of-State policy holders; ***charges base on Medical Necessity. Any non covered charges are the patients' responsibility.***
- NC Health Choice
- Medcost/Medcost Preferred
- Multiplan-Previously called Up& Up
- TriCare ***Standard Only***
- Workers Compensation
- Cigna Medicare ***Only***
- Medicaid (NC Only)

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

Patients with any other insurance must self-file. Patients that self-file must complete a self pay waiver, and pay in full at the time services are rendered. Some services may not be covered by your insurance policy. It is your responsibility to check your benefits ahead of time and to be prepared to make any out-of-pocket payments at the time of the visit.

Please be aware that your MENTAL HEALTH COVERAGE AND BENEFITS may differ from your medical. You are advised to verify your coverage.

These rates are *only* an estimate:

- Attention Deficit Disorder Evaluation \$630-\$1200
- Psycho-educational Evaluation \$1000-\$3000
- Neuropsychological Evaluation \$1500-\$3000
- Neuropsychiatry Evaluation \$630-\$3000
- Initial psychiatric/psychological consultation \$250-\$1200

The procedure code(s) that usually apply when checking MENTAL HEALTH INSURANCE BENEFITS for these evaluations are listed below. Some may need **PRE-AUTHORIZATION**. **Please check with your insurance company regarding pre-authorization.**

PROCEDURE CODES MOST COMMONLY USED:

99205(initial office visit medical)

90801(initial office visit psych)

99215(follow up visit medical)

90807(follow up visit psych)

96101(psychological testing per time unit)

96118(neuropsychological testing per time unit)

1829 E. Franklin Street, Bldg. 400
Chapel Hill, NC 27514
T 919 933-2000
F 919 933-2830

6911-100 Shannon Willow Road
Charlotte, NC 28226
T 704 529-4101
F 704 529-6655

2605 Blue Ridge Road, Suite 225
Raleigh, NC 27607
T 919 785-5055
F 919 573-6689

INSURANCE, BILLING AND COLLECTION POLICIES continued:

MISSED APPOINTMENT POLICY

A minimum of \$40 or a fee up to the amount of the scheduled visit will be charged for appointments missed.

All therapy visits that are a no show or same day cancellation will be charged a fee of \$75.

We require **24 HOUR IN ADVANCE CANCELLATION NOTICE**.

*after 3 no shows, you may be subject to being discharged from the practice

*Insurance companies do not reimburse for missed appointments fees. You will have to pay this out-of-pocket.

INSURANCE CHANGES

It is the patient's responsibility to inform our billing department of any insurance changes before the next scheduled appointment that is affected by this change.

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

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.

RETURNED CHECKS

A fee of \$40.00 will be added to your balance due, for returned checks.

Signature: I understand that I am legally responsible for my entire bill. NC Neuropsychiatry will file claims with participating insurance companies.

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____

PRINT _____ **DATE** _____

WITNESS SIGNATURE: _____ **DATE** _____

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