Family Psychiatry Practice & Associates Financial Policy and Agreement

APPOINTMENTS

The keeping of regular appointments is crucial to successful therapies. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you.

_____Our policy is to charge for missed appointments or appointments canceled with less than 24 hours' notice at the rate of the reserved session. You will be billed directly for this time.

PAYMENT OF FEES

_____FAMILY PSYCHIATRY PRACTICE & ASSOCIATES does not participate with any insurance plan nor do we file on your behalf. We will provide you with all necessary paperwork to assist you in filing with your insurance company. Payment to FAMILY PSYCHIATRY PRACTICE & ASSOCIATES is to be made in full at the time of service. We accept cash, check, MasterCard/Visa, and Discover. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

_____I am not a Medicare or Medicaid patient.
By signing this, you are informing our office that you are not a Medicare or Medicaid patient. **If you are a Medicare or Medicaid patient, please inform our front desk staff. Additional paperwork may be required.**

REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS

_____Any reports or professional consultations involving time beyond that of the regular scheduled session will be billed at a pro-rated charge for the professional time involved.
_____We will charge for telephone, email and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should your provider deem it appropriate.
_____ Psychiatric/Psychological Testing results may not be released until the testing bill is paid in full.

CONSENT TO RELEASE OF INFORMATION

Patient agrees that his/her clinician may share information with other professional staff at Family Psychiatry Practice & Associates regarding his/her case to better provide quality treatment. This information will be kept strictly confidential and remain in the confines of FAMILY PSYCHIATRY PRACTICE & ASSOCIATES only.

READ CAREFULLY AND SIGN

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

_____

Signature of Patient/Responsible Party Date

_____

Printed Name/Relationship to Patient