

# Psychiatric Services, LLC

## Office and Financial Policies

Welcome to our office! We are pleased that you have chosen us to provide your care and services. We would like to inform you of our payment policies. We accept cash, personal checks and credit cards for payment.

**No Insurance/Non Contracted Insurance:** If you have no insurance, we expect you to pay for your visit at the time of service. Non-contracted insurance will be billed if appropriate insurance information is given, however, payment will be expected at the time of service.

**Medicare:** Psychiatric Services LLC is participating provider for the Medicare program. We will submit your claim/ services to Medicare. If you have a secondary or supplemental, we will submit after payment from Medicare, however, we must have a copy of your card and the appropriate information.

**Medicaid and Medicaid HMO:** We **do not** participate with any Medicaid program. Please contact a Medicaid contracted provider for your care.

**Contracted Insurance (HMO, PPO, EPO, POS):** If you have insurance we are contracted with, we submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, the address to submit claims to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service and any amounts not covered by your insurance, including deductible. If your coverage is denied for any reason you are responsible for payment of the entire balance due, based on our normal fee schedule.

**Workers Compensation:** We will bill your workers compensation for your work related injury. We will need the claim number, the name of your insurance, the name and phone number of your adjuster. If your carrier determines it is not work related we will then bill you directly or your health insurance if you have provided us with this information at the time of service.

**Auto Accidents:** We will bill your auto insurance if you provide us with the name of your insurance, the claim number as well as the adjusters name and phone number. If your auto benefits are exhausted we will need the name of your health insurance or you will be responsible for the charges.

**Ancillary Services:** If lab work is needed, an order will be written. It is your responsibility to determine what facilities your insurance participates with to lower your costs.

**Co-payments:** Co-payments or co-insurance is due at the time of service prior to the appointment. A minimum of \$35.00 will be collected if no copayment is specified on your insurance card or we are not familiar with your behavioral health insurance.

**No Show Fees, Missed and Failed Appointments:** Your scheduled appointment time has been reserved for you with the provider. We cannot fill that space if you do not notify us at least 48 hours in advance of your inability to make the appointment. There is a charge of \$25.00 for late cancellations, \$50.00 for missed or failed follow-up appointments and \$150 for missed or failed new patient appointments with less than 48 hour notice. The no show, failed and late cancel fees are not billed to your insurance. Payment is due prior to rescheduling your appointment.

**Returned Check Fees:** Checks returned for insufficient funds or closure of account will have an additional fee of \$50.00 plus the amount that was due. You are responsible for any bank fees charged to you by your bank. Your account will be put on a cash pay only basis thereafter.



## Office and Financial Policies (Page 2 of 2)

**Copies of Records:** Records will be released and forwarded to a new psychiatric provider at no charge after a release is signed and witnessed. A fee of \$3.00 per page will be due prior to the records being released to additional providers, court or school.

**Preparation of Letters, Medical Excuses, or Other Special Reports or Forms Completion:** Please complete the patient portion of the form prior to submitting it to Psychiatric Services LLC. If the form must be completed between appointments, a fee of \$5.00 per minute will be charged and due upon completion and prior to be given to you.

**Legal Advocacy:** Legal fees are not reimbursed by medical insurance companies and are due and payable prior to the appointed time with a 5 business day cancelation policy. In office legal fees: \$250/hour. Out of office legal fees \$450/hour. If not canceled prior to 5 business days, the fees will remain the full fee.

**Refill of Medications:** Every effort is made to insure adequate refills are given to last until the next scheduled appointment. If a refill is needed or your pharmacy submits an additional refill request or replacement prescriptions are needed there will be a \$15.00 charge (not submitted to insurance).

**Assignment of Benefits and Authorization to Release Information:** I hereby assign my Medicare and/or any other insurance benefits to which I am entitled. I authorize and direct my insurance carriers(s) including private insurance, and other health /medical plan to issue payment by check(s) directly to Psychiatric Services LLC for services rendered to me or my dependents regardless of my insurance benefits, if any.

I authorize Psychiatric Services LLC to furnish and/or release any information necessary to insurance carriers concerning my illness or treatment to process my insurance claims and as requested or required by the insurance carrier for their audits. A photocopy of my signature can be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked in writing.

I have requested medical services from Psychiatric Services LLC on behalf of my dependents or myself and I understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. ***Insurance coverage is a matter between my insurance company and myself; I am ultimately responsible for the payment of my account.***

**"I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay up to an additional 50% of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection) plus any court costs and attorney's fees incurred in connection with the collection of my account."**

***I have had the opportunity to read and understand the payment policies set forth and have been given the opportunity to ask questions about these policies. I understand my responsibility for payment to Psychiatric Services LLC.***

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**Printed Name (Responsible Party over 18 years old)**

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**Signature**

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**Date**



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## PATIENT COPY



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Signature

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Date

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