Billing Policies for Psychiatric Associates

Please read carefully and sign below:

Please contact your insurance company to verify whether preauthorization is needed for mental health visits. Many insurance companies require authorization for mental health services even if authorization is not required for other medical services. **Payment from your insurance company could be reduced or denied if authorization is not obtained.** There may be instances your insurance company deems certain services as not "medically necessary" or "investigational". Please be aware while we will make every effort to obtain insurance reimbursement for your treatment, reimbursement is never guaranteed, which may leave the patient solely responsible for the full cost of treatment.

For your convenience we will submit the claim for your visit to your insurance company. Your portion of the charges (copay) and balances are due at the time of service. Please remember the insurance contract is between you and your insurance carrier. Questions about their payment and/or coverage should be directed to them. **Our office cannot guarantee insurance coverage for services provided.**

In the event of a delay or denial of your claim, you are responsible for payment in full in a timely manner. If payment cannot be made when due, please contact our Practice Administrator to set up an extended payment arrangement. After 90 days, if no payments have been received or arrangements made, necessary collection proceedings will begin. You will be responsible for all costs, including court costs and attorney fees, incurred in the collection of these charges.

Please note that we request 24 hours notice prior to canceling an appointment. **If less than 24 hours notice is given, you may be billed $25.00. The charge for missing an appointment without notification is $95.00. A $25.00 fee will be assessed for the completion of medical forms.** These include but are not limited to: bulletins, work excuses/releases, disability forms, FMLA forms, academic withdrawal and tuition reimbursement forms, etc. Insurance companies will not pay for these charges and you will be responsible for payment in full. ****Initials: _____**

When you sign this agreement you are responsible for payment of your bill. If you wish to arrange for someone else to have responsibility for some or your entire bill, you must arrange for them to sign a copy of this agreement. Until such a copy is on file, we must hold you responsible for the bill.

I have read the above information and agree to accept responsibility for payment.

_____ _____

Signature Date

_____ _____

Patient Name (Printed) Relationship, if not the patient

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Psychiatric Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Psychiatric Associates. I understand that diagnosis or treatment of me by Todd VerHoef, MD, Dana Weibel, MD, Kimberly VerHoef, MD, Christopher Welsh, MD, Ann M. Glick, MSN, ARNP, FPMHNP, Rustin Licht, MD, Adam Woods, MD, Megan Gosse, ARNP/DNP, Helga-Margot O'Brien ARNP/DNP, Kelcy Weibel PA, Barbara O'Rourke, RN, PhD, LMHC, Lisa Kim, MA, LISW, Erica Bobst RN, CRC, LMHC, Aileen Barnhouse, RN, LMHC, CRC, Sally Henderson, PhD, LMFT, Penny Clark MA, LMHC, ATR, Tina Issa, LMHC, CRC, CADC, Jennifer Sacora, LMHC, MA, Cynthia Vaske LISW, CEAP, CPC, Lanny Tygrett, LISW, Erin Maher, LMFT, Cynthia Prodzinski, LMHC, Miquel Anastasi-Melchert, LMHC, Sandra Kessler, LISW, Carmen Tillman LMHC(t), Devona Siron, LISW, Rae Noble, LMHC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Psychiatric Associates is not required to agree to the restrictions that I may request. However, if Psychiatric Associates agrees to a restriction that I request, the restriction is binding on Psychiatric Associates and Todd VerHoef, MD, Dana Weibel, MD, Kimberly VerHoef, MD, Christopher Welsh, MD, Ann M. Glick, MSN, ARNP, FPMHNP, Rustin Licht, MD, Adam Woods, MD, Megan Gosse, ARNP/DNP, Helga-Margot O'Brien ARNP/DNP, Kelcy Weibel PA, Barbara O'Rourke, RN, PhD, LMHC, Lisa Kim, MA, LISW, Erica Bobst RN, CRC, LMHC, Aileen Barnhouse, RN, LMHC, CRC, Sally Henderson, PhD, LMFT, Penny Clark MA, LMHC, ATR, Tina Issa, LMHC, CRC, CADC, Jennifer Sacora, LMHC, MA, Cynthia Vaske LISW, CEAP, CPC, Lanny Tygrett, LISW, Erin Maher, LMFT, Cynthia Prodzinski, LMHC, Miquel Anastasi-Melchert, LMHC, Sandra Kessler, LISW, Carmen Tillman LMHC(t), Devona Siron, LISW, Rae Noble, LMHC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Todd VerHoef, MD, Dana Weibel, MD, Kimberly VerHoef, MD, Christopher Welsh, MD, Ann M. Glick, MSN, ARNP, FPMHNP, Rustin Licht, MD, Adam Woods, MD, Megan Gosse, ARNP/DNP, Helga-Margot O'Brien ARNP/DNP, Kelcy Weibel PA, Barbara O'Rourke, RN, PhD, LMHC, Lisa Kim, MA, LISW, Erica Bobst RN, CRC, LMHC, Aileen Barnhouse, RN, LMHC, CRC, Sally Henderson, PhD, LMFT, Penny Clark MA, LMHC, ATR, Tina Issa, LMHC, CRC, CADC, Jennifer Sacora, LMHC, MA, Cynthia Vaske LISW, CEAP, CPC, Lanny Tygrett, LISW, Erin Maher, LMFT, Cynthia Prodzinski, LMHC, Miquel Anastasi-Melchert, LMHC, Sandra Kessler, LISW, Carmen Tillman LMHC(t), Devona Siron, LISW, Rae Noble, LMHC or Psychiatric Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Psychiatric Associates Notice of Privacy Practices prior to signing this document. The Psychiatric Associates Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Psychiatric Associates. The Notice of Privacy Practices for Psychiatric Associates is also provided in the waiting room of Psychiatric Associates. This Notice of Privacy Practices also describes my rights and Psychiatric Associates duties with respect to my protected health information.

Psychiatric Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: _____

Name of Patient or Personal Representative:

_____ Date: _____

Revised 8/2018