psychbc

STATEMENT OF UNDERSTANDING REGARDING SERVICES

I understand that I AM RESPONSIBLE for my bill, except when otherwise limited.

I authorize payment directly to my medical provider.

I accept responsibility to obtain referrals/authorizations/pre-certification for any/all services required for my treatment, except when otherwise prohibited by my insurer or its designated managed care company.

I understand that copayments, by law, are due at time of service.

I understand that I am responsible for outstanding account balances that are not covered by my insurance. This includes copayments, deductibles and broken appointment charges.

I understand that I will be charged for all broken appointments if not cancelled 24 hours prior to the appointment time.

I understand that in order to provide me with safe and proper medical care, prescriptions can only be provided in coordination with regular office visits. I also understand that refills of prescriptions will be issued at the time of a follow-up visit with my medical provider and that requests for medication refills without an office visit will incur a $25 administrative fee, non-reimbursable by insurance.

Paperwork should be brought to the appointment with my medical provider and completed during the appointment. I understand that, except when prohibited by law, I will be charged for the preparation of reports or the completion of other types of paperwork and forms when this requires attention outside of the normal appointment time.

I understand that I am responsible for notifying my medical provider within 30 days of any change to my insurance contract. Failure to notify the office regarding insurance changes may lead to non-payment by the insurer. In such a case, I will be responsible for the unpaid fee.

Patient's Name: _____

Patient's Signature: _____Date: _____

Responsible Party: _____

If patient is under 18 or designates someone as financially responsible for fee incurred.