

FINANCIAL POLICIES AGREEMENT

Payment for services provided by Comprehensive Psychiatric Associates is due at the time services are rendered unless payment by health insurance has been arranged prior to the visit. If insurance coverage has been arranged, payment of any applicable copayment or deductible is due at the time services are rendered. If we do not have a contractual provider relationship with your insurance plan, full payment for services is due at the time services are provided. We will bill your insurance for you, and reimburse you if we receive payment. You agree to be fully responsible for payment for all services not covered by your insurance. If there is a problem with your insurance coverage, you agree to pay your bill and deal with your insurance company yourself. As a courtesy to you, we will attempt to verify your insurance coverage and determine your insurance benefits. However, if your insurance company has misinformed us or you feel we have misinformed or failed to adequately inform you regarding your benefits, you are still responsible for payment of all charges not covered by your insurance. We encourage you to verify your insurance benefits and coverage yourself and to make sure that you fully understand your coverage. By signing this agreement, you agree to be responsible for all charges for the client identified below, even if you believe that some other party should bear responsibility for these charges.

Some services may not be covered by health insurance. This may include charges for telephone consultation, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive telephone consultation or other than routine written correspondence or reports are requested or required, a charge for these services will be applied. Every effort will be made to notify you if such a charge is likely to occur. However, the exact amount charged cannot always be predicted.

When an appointment is missed or canceled without at least 48 hours prior notification, the full fee applicable to the canceled appointment may be charged. If the appointment falls on the first business day of the week, notification of cancellation must be received by noon of the last business day of the preceding week. Fees charged for missed appointments or late cancellations must be paid prior to the next appointment. A service charge of 1.5% of the outstanding balance or a minimum of \$5.00 will be added each 30 day billing cycle to all outstanding self-pay balances over 60 days past due. A charge of \$25.00 will be applied for all checks returned unpaid. If an overdue account is sent to a collection agency, collection fees and expenses will be added to the amount due. A copy of the currently applicable fee schedule of Comprehensive Psychiatric Associates is available upon request. Fees may be modified without notice.

ACKNOWLEDGEMENT AND AGREEMENT

I have read the above and affirm that everything in this form that was not clear to me has been explained to my satisfaction. I understand that it is my responsibility to know my insurance benefits. I hereby agree to abide by the policies specified above and to be responsible for all fees and charges for services provided by Comprehensive Psychiatric Associates to or on behalf of the client named below. This agreement will continue as long as Comprehensive Psychiatric Associates provides services or until a written request that this agreement be terminated is received by Comprehensive Psychiatric Associates.

Assignment of Health Insurance Benefits: The signature below authorizes payment directly to Comprehensive Psychiatric Associates of benefits payable under the health insurance policy covering the client named below. A photocopy of this form is to be considered as valid as the original. For Medicare Clients Only: The undersigned hereby requests that payment of authorized benefits be made to Comprehensive Psychiatric Associates on behalf of the client named below. The undersigned authorizes any holder of medical information about the client to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. A photocopy of this form is to be considered as valid as the original.

_____ Signature of Client	_____ Name of Client, Printed	_____ Date
_____ Signature of Responsible Party	_____ Name of Responsible Party, Printed	_____ Date

We ask to keep a signature and credit card information on file for every client. In the event that you cannot or do not pay whatever fees are your responsibility at the time of your visit, we will submit the charge to your credit card. We ask you to sign below indicating your agreement and consent to this procedure. Your card will be charged only if you do not pay at the time of your visit, or if there are outstanding charges for missed appointments or late cancellations.

_____ Card Type	_____ Name on Card	_____ Card Number	_____ Exp Date
_____ Signature of Card Holder	_____ Name of Card Holder, Printed	_____ Date	