Integrated Behavioral Health

Financial Agreement Policy

Patient Name: _____ DOB: _____

Payment is due at the time services are rendered. We accept most forms of payment. There will be a $35.00 service charge for NSF of returned check.

A 24-Hour notice for cancellation is required. Call reminders are a courtesy. Please always remember to get a printout of your appointments.

_____ (initial) for late cancellation or same day cancellation, you will be charged $50.00

_____ (initial) For No Shows, you will be charged $50.00 (3 or more no-shows will result in possible dismissal as a patient.)

_____ (initial) if you are more than 5 minutes late for your appointment and we are unable to schedule you for a later appointment on the same day, you will be charged $50.00

All fees must be paid before you can reschedule an appointment. If you have any future appointments they may be cancelled until all fees are paid.

Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement. Your insurance may confirm your benefits, but confirmation of benefits is not a guarantee of payment; you will be responsible for any unpaid balance. _____ (initial)

It is your responsibility to know if your insurance has any deductible, copayment, co-insurance, out-of-network, visit limit, prior authorization requirements, or any other type of benefit limitation for the services you receive. _____ (initial)

I understand and agree that it is my responsibility to know if my insurance requires a referral or authorization and that it is up to me to obtain. I understand that if a referral/authorization is required but not obtained that I will be financially responsible for all services rendered. _____ (initial)

I agree to inform the office of any changes in my insurance coverage prior to my appointment. I understand that if I do not provide this information prior to my appointment I may be charged the self-pay rate. _____ (initial)

In an effort to improve the ability to make informed medical decisions, your physician or nurse practitioner requires that a urine drug screen (UDS) be completed randomly. Although a valuable diagnostic tool, your insurance carrier may not cover associated cost. As a result, you will be charged a $10.00 fee to cover the cost of the screen. _____ (initial)

You will be financially responsible for letters or forms completed by your provider. Fees vary but will not exceed $95.00. Completion of letters or forms is at the provider's discretion. The provider has up to 30 days to complete any letters or forms. _____ (initial)

I understand that if I no-show, same day cancel, or reschedule an appointment and I do not have enough medication to get to my next scheduled appointment I will be charged a refill fee of $25.00. _____ (initial)

_____ _____

Signature of Patient or Person granting Authorization on behalf of patient Date

Relationship to Patient: _____