INSURANCE INFORMATION AND FINANCIAL AGREEMENT

Office Financial and Insurance Policies

In many cases we will be able to call to verify your coverage before your first visit. If benefits cannot be determined before your visit and/or there is any doubt about your coverage, payment in full is expected at the beginning of your scheduled appointment. If your insurance company remits payment you will then be reimbursed or we may carry the balance as a credit toward future copayments. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does **not** guarantee payment. As it is not uncommon for an insurance company to misquote a policy we recommend that you review your policy to confirm that the information we receive is correct.

I hereby authorize payment of insurance benefits made on my behalf to Mill Street Psychiatric, or to Jan Maybee FNP, PMHNP for any services provided to me through their office. I understand that I am financially responsible to Mill Street Psychiatric for charges not paid by my insurance carrier. If an unpaid balance is sent to a collection agency, I will also be responsible for any legal fees, expenses, and/or interest associated with the collection of the debt.
Initial Here_____

I understand that it is my responsibility to pay for visits/treatment not paid by my insurance within the usual and customary time frame (30 - 90 days). If after 90 days I would like Mill Street Psychiatric to continue to pursue billing my insurance carrier, I accept that I will be charged $15 per repeated claim to defray the costs associated with the additional time spent pursuing insurance payment. **Initial Here_____**

METHODS OF PAYMENT

We currently accept cash, checks, debit, Visa, Mastercard, and American Express. We charge $25 for any returned checks or credit card charge backs to cover bank fees. We understand that on occasion financial problems may affect timely payment on your account. If such a situation arises, please contact our office promptly so that payment arrangements can be made. In the event account must be referred to a third party for collection, you agree to pay all reasonable collection and/or attorney fees, as well as court costs incurred to effect collection.

AUTHORIZATIONS

I have read the above information and agree, regardless of my insurance status, to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance carrier deems to be a patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.
I authorize the release of any medical or other information necessary to process my claims.
I authorize payment of medical or mental health benefits to Mill Street Psychiatric for all services rendered.

Name (print):_____
Patients or Authorized Person's name

Signature:_____ Date_____

Mill Street Psychiatric
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