# OUR OFFICE POLICIES AND PROCEDURES

Welcome to our practice. Thank you for choosing us as your mental health care provider. We are committed to your treatment being successful. We request that all patients complete, sign and return new patient information forms at the time of the initial visit. We ask that you please read the following office policies to familiarize yourself with our office, after reading please sign. THANK YOU!

**FULL PAYMENT IS DUE A TIME OF SERVICE**

Estimates for professional services are available for co-payments, coinsurance and /or deductibles. Or office accepts payment via cash, check, and credit cards.

**CHECK PAYMENTS**

We will charge a $25.00 fee for any checks written and not honored by your bank. This is in addition to any charges your bank may charge you.

**INSURANCE**

We must stress as mental health care providers, our relationship is with you and not your insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, we are not a party to that contract. In the event we do not accept assignment of benefits, we require that you pay the deductible (or proof that you have done so) and pay the estimated portion of your bill at the time of service. We often accept assignment of insurance benefits, however, that balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us your complete insurance information.

We allow 60 days for your insurance company to pay. In the event your insurance has not paid within that 60 day period, the bill will then be turned over to you and you will be responsible to pay within the next 30 days. At that time wry also will resubmit to your insurance company for the last time. A simple call to your insurance company fro you will greatly facilitate the payment. Remember payment for your

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Bill is always your responsibility. What we collect from you at the time of service is only an estimate. After receiving your insurance payment, we will bill you or refund you, whatever the difference.

**USUAL AND CUSTOMARY RATES**

This practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

**REPORTS AND MEDIAL RECORD RQUESTS**

Preparation of report of patient’s mental health status, history, treatment, or progress (other than for consultative purposes)) for other providers, agencies, or insurance carriers may result in a prep/copy fee. In some cases, payment may be required at time of request.

**MINOR PATIENTS**

Patients, under the age of 18, are considered minors and need to be accompanied by an adult in order to be treated. The parent adult or guardian accompanying the child during the child’s appointment is responsible for full payment.

**MISSED APPOINTMENTS**

Unless cancelled at least 24 hours in advance, our policy is to charge $50.00 for missed appointments. When patients fail to arrive to their appointments, our practice loses that time set aside which could

Have been used to treat other people in need. Please help us serve you better by keeping scheduled appointments.

**GRIEVANCES**

If you experience an incident or have a complaint, please ask our staff for a patient grievance form once our office receives a grievance form, appropriate action will be taken to resolve the issue.

**ACKNOWLDGEMENT**

**I have been provided an opportunity to review Notice of Privacy Practices above.**

**I authorize Guidance Foundation, my Behavioral Health Practitioner, to (Please indicate your preference(s) below)**

Leave messages on my answering machine Yes No

Leave messages with my spouse/partner Yes No

Leave messages with another person in household Yes No

(Other please explain)

*My signature below means I have read the policies, understand them and agree to abide by them.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_