plaza PSYCHOLOGY PSYCHIATRY

plazapsych.com ● (401) 356-1940 ● fax (401) 356-1949

PATIENT FINANCIAL AGREEMENT

Our primary goal is to provide you with quality mental health care. In order to allow our staff to focus on your mental health care, we have developed the following policies regarding payment for services.

INSURANCE INFORMATION:

- *It is your responsibility to ensure that we have accurate insurance information. If an insurance claim is rejected as a result of incorrect information you provided, you are responsible for payment. If you have multiple insurance policies, you must inform us of each and every policy for each family member. It is your responsibility to know which insurer is primary and to inform us.*
- *Plaza Psychology & Psychiatry will submit claims to your insurance company on your behalf. You give us permission to provide your insurer(s) with any information necessary for payment. You give us permission to ask your insurer to pay us directly for care we provide.*

COPAYMENTS/DEDUCTIBLES:

- *It is your responsibility to understand any deductible/coinsurance or copay that may apply to you under your insurance policy.*
- *If you have a copay, your insurance company requires it to be paid at the time of each visit. We accept cash, check or money order. If you are unprepared to pay a copayment at the time of your visit,* ***you will not be seen by your provider****.*
- *You will be expected to pay ½ of any outstanding balance at the time of your visit.*
- *If your check is returned, a $25.00 returned check fee will be assessed. After two subsequent returned checks, you will be required to pay by cash or certified check only.*
- *If you do not have insurance coverage, you will be expected to pay the out of pocket cost at the time of your visit.*
- *Our billing department will send out billing statements for outstanding balances. If the balance is still unpaid after four statements, your account will automatically be sent to our collection agency. It is the policy of our collection agency to report delinquent accounts to credit bureaus.*
- *Small balances can be collected at your visit, and may not generate a bill.*

HOME ADDRESS/TELEPHONE:

- *Please keep us informed of any changes in your phone number, address and insurance.*
- *It is important that we have accurate information on the guarantor. This is the person who is financially responsible for your bills.*

PATIENT RESPONSIBILITIES:

- *Our billing staff is available to provide you with assistance, but cannot resolve disputes between you and your insurance company.*
- *It is your responsibility to keep your scheduled appointments. Missed appointments may result in additional charges or dismissal from our practice. Please call our office at least 24 hours in advance if you are not able to keep an appointment in order to avoid a Late Cancellation or No-Show fee.*
- *Please supply your credit card number below to indicate your permission to have Plaza Psychology charge for late cancellations and no-shows:*

  _____ *Exp. Date:*_____ *Security #:*_____

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND THAT YOU UNDERSAND OUR FINANCIAL AGREEMENT:

_____ _____

Signature *Date*

_____

Signature of Parent/Guardian