Financial Policy Acknowledgement

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect the patient responsibility amount due. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES WITH YOUR INSURANCE. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

Lake Area Psychiatry has preferred provider contracts with several major insurance companies. Please contact your insurance company to determine if our practice has a contract with *your* insurance company. Any financial portion that is the "member's responsibility" such as deductible or a non-covered percentage will be collected ***at the time of service.*** _____**(initial)** If, for any reason, it is not collected at the time of service, a billing fee will be added to your outstanding balance for each statement that is mailed._____**(Initial)** Remember, your insurance coverage is a contract between you and your insurance company. Lake Area Psychiatry is not responsible for services denied by your insurance company.____**(initial)**

PPO INSURANCE PLANS: We have agreed to accept discounted rates from plans we participate in, however all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since co-pays are estimates only, we will bill you or credit you for your balance.

NON-CONTRACTED INSURANCE PLANS: We have not agreed to accept discounted rates from plans that are not contracted with Lake Area Psychiatry, therefore, all co-insurance and deductibles are your responsibility.

INDEMNITY INSURANCE PLANS: We will estimate co-pays to the best of our ability. Since co-pays are estimates only, we will bill you are credit you for the balance.

DIVORCE DECREE: We are not a party to your divorce decree. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

PAYMENTS: We accept cash, debit cards, Visa, MasterCard, Discover Card, and personal checks (with photo id only). Any outstanding balances are due within 30 days of statement. The second and each subsequent statement will be assessed a $5 rebilling fee. All balances older than 90 days may be sent to a collection agency.
Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.

RETURNED CHECKS: Checks returned to us by the bank will be assessed a $35 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency. In addition, we will only accept cash or credit card for any future visits.

MISSED APPOINTMENTS: (Please refer to the attached Cancelled/Missed Appointments Agreement attached)

I authorize treatment and accept the financial responsibility for myself or my minor child that I am accompanying. I am responsible for all fees and will assure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims.

I have read and fully understand the financial policies of Lake Area Psychiatry, and agree to the terms. I also understand that the terms of theses financial policies may be amended by the Practice at any time without prior notification

_____ _____

Patient/Parent/Guardian/Personal Representative Date