South Hills Integrated Psychiatric Services, P.C.

205 E. McMurray Rd. McMurray, PA 15317 Ph: 724/ 9418760 Fax: 724/ 941-8795 SHIPsych.com

Patient Name (PRINT):____ DATE of BIRTH: _____________________

PATIENT RIGHTS/RESPONSIBILITIES & FINANCIAL POLICY

I have a right to privacy and confidentiality. All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my provider or insurance carrier/managed care company to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others. In these cases I understand that my provider may have to break confidentiality. I understand that in order for my insurance or managed care company to pay for services my provider must submit to the company a diagnosis which describes a mental disorder of which I or my child suffers. This information is often stored in a medical information data bank that other insurance companies may access when I apply for insurance. I realize that if I do not wish to release this information, I must pay out of pocket for services.

My health is my responsibility. I will contact an emergency provider if after normal office hours, as well as my treatment provider for any serious situation that rises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my treatment provider of changes in my condition. I understand that I can terminate treatment at any time.

Informed Consent: By signing below I acknowledge reading, understanding, and agreeing with the above policies and information. I understand that if I do not understand or have any questions about these policies, I may discuss them with my provider.

SIGNATURE: ____ DATE: __________________

South Hills Integrated Psychiatric Services, P.C. (SHIPS) is committed to partnering you to provide with high quality, sustainable care. As such, it is very important to discuss the practice fees and expectations of financial responsibilities. Your clear understanding of the practice financial policy is important to our professional relationship. Please ask if you have any questions.

- **I have read the PATIENT/ GUARANTOR FINANCIAL RESPONSIBILITIES (on reverse) and understand the practice financial policy.**
- **I understand that there is a charge for failed appointments/ late cancellation of appointments (when less than a 24 hour notice from the start of the scheduled appointment) is given. You will be charged the full fee for the service which would have been rendered. One time per year, per patient this fee can be waived as a courtesy. Reminder calls/ messages to our patients are offered as a courtesy only. This policy is subject to change at any time.**
- **In the event my insurance company deems a service to be a non-covered I understand that I am personally responsible for 100% payment.**
- **I agree to the release of any and all medical/ psychiatric information, and financial information necessary to process this and any future claims to the patient's insurer or payer of health benefits.**
- **Payments are due as per practice policy and may be made by cash (in exact amounts only), credit card (Visa, Master Card, Discover), or check. In the event a personal check is returned unpaid from your bank, your account will be charged with a returned check fee of $35, and your account may be placed on a "cash only" basis for up to 365 days.**

ASSIGNMENT OF BENEFITS and FINANCIAL POLICY AGREEMENT: I authorize payment of insurance benefits to South Hills Integrated Psychiatric Services, P.C. for services rendered and agree to the terms outlined in this agreement.

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SIGNATURE Patient/ Legal Guardian DATE

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PRINT Name & Relationship to Patient

PATIENT/ GUARANTOR FINANCIAL RESPONSIBILITIES

Thank you for choosing South Hills Integrated Psychiatric Services. This information is provided to you to help you understand our financial, insurance, billing, and payment policies. Please be a responsible financial partner:

- A copy of the practice financial policy is available on the practice website at http://www.shipsych.com/insurance-payment/.
- If you have valid coverage with a participating insurance carrier, SHIPS will file an insurance claim as a courtesy. If there are any problems with this submission, you will be notified immediately and your prompt assistance is required with any conditions under your control that are causing a delay in processing. If your insurance carrier does not respond within 30 days, we will submit a second claim. If your insurance carrier does not respond to our secondary submission within 30 days from the second claim submission, payment will become your responsibility. You will need to contact your insurance carrier if you think it is responsible for payment and request payment reimbursement from them. SHIPS will expect full payment from you within 14 days of this notification.
- Know your insurance benefits. Your insurance policy is a contract between you and your insurance company, even if your employer provides it. There are many subtle differences in insurance policies, and employers frequently change coverage and co-payments. You are responsible for knowing what services are covered, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance doesn't cover, or for which you have a deductible that has not yet been met. If you are utilizing my care via insurance benefits, you must immediately update the practice if your insurance company or benefits change. You must understand the policy medical and behavioral health benefits and remain up to date. This is your 100% responsibility.
- Carefully read all Explanation of Benefits (EOB) statements you receive from your insurance carrier. We receive the same statements, and any charges which your insurance carrier designates as "patient responsibility" will be expected to be paid upon our receipt of the insurance statement.
- If your account is self-paid, full payment for all services rendered will be expected at time of the appointment, and it will be your responsibility to submit any claims to your insurance company for direct reimbursement to you. This may include situations where we cannot validate active in network coverage with your reported insurance carrier. In such cases, full payment will be collected at time of service and any amounts subsequently collected from your carrier will be refunded to you.
- Co-pays as well as any other out-of-pocket expenses incurred during or between visits are due immediately upon receipt of service -- cash (in exact amount only), credit cards (VISA, MasterCard, Discover), and checks are accepted. Itemized practice receipts for these transactions will be given at the next office visit, unless other arrangements are requested.
- Effective for all services rendered on or after 2/15/2015, the practice policy requires all patients to have a credit card on file for use as authorized by the *Credit Card on File agreement*. Without this authorized agreement and the maintenance of a valid and current credit card on file, a billing fee of $15.00 will be added to your account for each written statement that the practice must send to attempt to collect an owed balance. Furthermore, an "outstanding balance" charge of 10 % of the total bill will be charged for each month that the bill remains unpaid.
- If you are unable to pay your account balance in full and/ or in a timely manner, please communicate this with the practice—every effort will be made to work with you. An agreed upon payment plan will be required to remain in good standing with the practice. Failure to make progress toward resolving outstanding account balances will result in late payment charges, collection actions, and will compromise your ability to be treated within this practice.
- A full practice fee schedule is available upon request. Please note that fees are subject to change without notification. As a courtesy, every effort will be made to inform families known to be paying for services out of pocket if the fee schedule is significantly modified.
- Please know whether your insurance coverage is contingent upon the designated insured party completing the annual documentation (COB documentation, etc.) required by the insurance company. If the required items are not completed on the insurance company's timeframe, the insurance will deny every medical claim made on the policy until this requirement is satisfied. In the event of this type of insurance denial, you will be held fully financially responsible for any claims denied by the insurance, payment will be expected in full from you in lieu of the insurance payment, and you will have to attempt to rectify the denial with the insurance on your own behalf.
- All statements are due upon receipt. If charges remain unpaid after 45 days, a final statement will be rendered with a letter sent informing you that our relationship is subject to cancellation after 30 days of urgent and emergent care. All further services will be provided on a cash only basis.
- We reserve the right to place your account with a collection agency after all internal efforts to obtain payment have been exhausted. You are then responsible for any collection costs in addition to your outstanding bill. Treatment cannot be ethically continued within a solo private practice once an account has been submitted to collection. Prior to this, notification will be sent to responsible party of intention to submit to account to collection and treatment must be otherwise secured by the responsible party at that time.