453 Valley Brook Rd. Suite 500, 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 for my insurance or managed care company to reimburse for services/ medications my provider may need to 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/ medications and not submit items to insurance for reimbursement.

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: _________________
PATIENT, if over 18 yrs old/ LEGAL GUARDIAN

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 (page 2) and understand the practice financial policy.
- I understand that there is a charge for failed appointments/ late cancellation of appointments (when less than a 48 business hours 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. *Reminder calls/ messages to our patients are offered as a courtesy only.* This policy is subject to change at any time.
- I understand that South Hills Integrated Psychiatric Services, P.C. is out of network with all insurance providers.
- I agree to the release of any and all medical/ psychiatric information, and financial information necessary to aid in the process any 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, AMEX), 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 $50, and your account may be placed on a "cash only" basis for up to 365 days.

FINANCIAL POLICY AGREEMENT: I agree to the terms outlined in this agreement and accept full financial responsibility for payment of all services rendered.

____ _____________________
SIGNATURE Patient, if over 18 years old DATE

____ _____________________
SIGNATURE Legal Guardian/ Financial Guarantor, for all patients DATE

____
PRINT Name of Financial Guarantor, & 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 this practice financial policy is available on the practice website at http://www.shipsych.com/insurance-payment/.**
- **Payment is due immediately upon receipt of service -- cash (in exact amount only), credit cards (VISA, MasterCard, Discover, AMEX), and checks are accepted. Itemized practice receipt for these expenses will be given upon request.**
- **The practice requires all active patients to have a credit card on file- terms per Credit Card on File agreement. (Effective date 2/15/15)**
- **Notification for credit card charges will be furnished to payer immediately upon completion of transactions from cardholder's account.**
- **If you are unable to pay your account balance in full and 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, though, as a courtesy, every effort will be made to inform families if the fee schedule is significantly modified.**
- **You are welcome submit your visits to your insurance company to attempt to be reimbursed for our out of network care. Please understand that your insurance coverage is a contract between you and your insurance provider. Our office is out of network with all insurers; therefore we cannot take any responsibility in this process. Our office will provide you with itemized receipts of payments, upon request, and credit card receipts if paying via credit card. Additional documentation for insurance purposes are the patient/ guardian responsibility. We will not work with insurance companies regarding reimbursement issues.**
- **In the event a personal check is returned unpaid from your bank, your account will be charged with a returned check fee of $50, and your account may be placed on a "cash only" basis for up to 365 days.**