

ADVANCE BENEFICIARY NOTICE, ASSIGNMENT OF INSURANCE BENEFITS FOR SERVICES RENDERED AT PSYCHOLOGICAL MEDICINE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself/dependents. I further expressly agree and acknowledge that my signature on this document authorizes my clinician to submit claims for benefits, for services rendered or for services to be rendered; without obtaining my signature on each and every claim to be submitted for myself/dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I _____ hereby authorize my insurance carrier to pay and hereby assign directly to Psychological Medicine all benefits if any; otherwise payable to me for his/her services. I understand that I am financially responsible for all charges incurred. I agree to make co-payment at the time of service, as indicated by my current insurance policy.

Psychological Medicine agrees to submit a claim for services rendered as a courtesy. I acknowledge that any insurance benefits, when received by and paid to Psychological Medicine will be credited to my account.

If my insurance carrier denies payment, I agree to be personally and fully responsible for payment. Furthermore, I understand Psychological Medicine is unable to send claims to my carrier if I have not provided current and complete information. In the event that I request a claim to be resubmitted on my behalf, I may be charged a rebilling fee. I have contacted my insurance carrier for benefit information and agree to contact my insurance carrier for questions regarding payments, denials and benefit changes.

If my insurance carrier sends me the check for services rendered by Psychological Medicine, I hereby will be fully liable and responsible for amount due if the insurance check is not brought or mailed to the Psychological Medicine office for payment on services.

CANCELLATION POLICY

It is very important for your treatment at Psychological Medicine that you keep each scheduled appointment. When you miss one appointment, it can interfere with your treatment plan. As a patient of this office, it is your responsibility to notify us at least 24 hours in advance of any appointment you are unable to keep. If you do not notify our office, you will be charged. This fee is not billable to your insurance carrier and is the patient's responsibility. If you fail to keep two appointments in a row, your treatment will be ended. Any exceptions will need to be approved by the treating clinician and the office manager.

CONSENT FOR TREATMENT

NOTE: Please read the following statements carefully. Ask any questions you wish to help you understand each statement. Your signature at the bottom of this form indicates your understanding and agreement with each statement, and is your permission for us to provide services as indicated below.

I authorize Psychological Medicine to provide those evaluations, treatment, and consultation services which the agency or contract agencies consider necessary, and which have been approved by me. I realize that treatment does require a mutually agreed upon Individual Plan of Service, and my participation is voluntary.

I understand that my records and progress notes may be presented during staffing conferences for supervisory or consultation purposes, and that this will occur within this agency only. In addition, there may be times when records are reviewed for auditing purposes.

If I am a parent of a minor, I understand that I may be expected to participate in services provided to my child(ren). I consent for the evaluation and treatment of my child(ren).

I have been advised of the billing system used by this agency, and understand my responsibilities for the assessed fee.

I understand that this consent is valid for one year; however, I may withdraw this Consent for Treatment in written or verbal form to my clinician. I understand that a new consent will be obtained after one year or if a change in guardianship occurs.

Client's Signature

Date

Parent or Guardian's Signature

Date

Witness Signature

Date