Seasons Psychiatric Clinic
Financial and Office Policies

(Please read and initial ***each*** policy - front & back)

Patient Name: _____ Date of Birth: _____

Initial _____ **Insurance Plans**: I understand that it is my responsibility to confirm with my insurance company that the provider is currently under contract with my plan or I will be willing to be seen at "out of network" benefits. Any question about mental health coverage should be directed to my insurance carrier prior to my visits. I agree to be responsible for all copays, deductibles, and non-covered services determined by my insurance plan (including No Show fees and Missed Appointment fees).

Initial _____ **Self-Pay**: If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due in full at the time of service.

Initial _____ **Payments**: I agree I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for the services rendered by the practice doctor within 45 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my account in the event that the insurance eventually pays. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will be my responsibility as the patient.

Initial _____ **Collections**: I understand that all accounts that have not been paid within 60 days will be forwarded to Seasons Psychiatric Clinic's collection agency. Patients who have had their past due accounts turned over to the collection agency will be dismissed as a patient from Seasons Psychiatric Clinic.

Initial _____ **Check-In**: Copays and past due balances are due at the time of check-in. Please come prepared to pay. If you do not have your copay or have not come prepared to pay past due balances, your appointment may be rescheduled for a later time so that you may meet your obligation. Please also bring your current insurance card with you at each visit. For all visits we will ask you to verify insurance and demographic information so that our records remain current.

Initial _____ **Appointments and Late Arrivals**: We require patients to arrive on time for their scheduled appointments. When patients arrive late, it is impossible to stay on schedule. If you arrive more than 10 minutes past your scheduled appointment time you may be asked to reschedule your appointment.

Initial _____ **Courtesy Reminder Calls**: Courtesy reminder calls will be made the day before the appointment. If a courtesy call is not made, I agree that I am ultimately responsible for remembering my appointment date and time. Reminder cards will also be given at the time a follow up appointment is scheduled. Reminder calls are typically made to the phone number provided at the first visit. I agree that the clinic may call this phone number, unless notified otherwise.

Initial _____ **No Show/Missed Appointment**: We expect patients/parents to give us plenty of notice (at least 24 hours prior) if they are unable to keep their appointment. When you make a commitment to an appointment, other patients lose the opportunity of scheduling that date or time and the doctor makes a commitment to you for her time. If you do not give the proper cancellation notice to our clinic before your Initial Assessment you will be financially responsible for the full cost of the visit

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($250). Additionally, any follow up visits that we do not receive proper notice of cancellation, prior to the visit, will be charged a $50 No Show/Cancellation fee. If you miss 3 or more appointments within a year you may be dismissed from the clinic. Patient dismissal is at the discretion of your medical provider.

Initial _____ **Minors**: Unaccompanied minors must have a written authorization for mental health treatment signed by the parent or guardian before treatment can be rendered. Parents must be available by telephone if the doctor needs to contact them. The responsibility for copays, deductibles and fees for non-covered services, rests with the parent/legal guardian.

Initial _____ **Stimulant Medication:** Stimulant medications prescribed for ADHD (i.e., Adderall, Vyvanse, etc.) are considered controlled substances. This means that a new *written* prescription must be presented to the pharmacy each time the prescription is filled. These prescriptions **CANNOT** be phoned or faxed into the pharmacy. Lost prescriptions will not be replaced. Stolen prescriptions will only be replaced if the patient presents a police report documenting the theft. Additionally, stimulant prescriptions can only be issued at a regularly scheduled appointment. Please plan accordingly.

Initial _____ **Confidentiality**: Healthcare information is protected by law and requires your authorization for disclosure except for information needed to facilitate treatment planning, payment, or health care operations. The law also mandates that the provider release information in the following circumstances without your permission: cases of suspected child/elder abuse, imminent danger to self or others, and subpoena for legal proceedings.

Initial _____ **Professional Disclosure Statement**: I have read the Professional Disclosure Statement which can be found online at seasonsclinic.org. I request and consent to engage in treatment with **Dr. Janet Somlyay, DNP, APRN, PMHNP,** understanding this will be a collaborative approach, including but not limited to the services and therapies referred to in this document. I have discussed any concerns about the treatment process, and I agree to the contract terms as stated in the statement. I understand that a complete copy of the Professional Disclosure Statement is available to me any time online and by request of the office staff.

I have read, understood and agree to the above office policies. **I understand that non-compliance with this policy may result in termination of care and/or transfer of care to another practice.**

Patient Name: _____ **Date**: _____

Patient Signature: _____ **Date**: _____

Parent/Legal Guardian Signature: _____ **Date**: _____

Provider Signature: _____ **Date**: _____

As of January 1, 2020