Loudoun Psychiatric Care.

44790 Maynard Square, Suite # 130 Ashburn, VA 20147

Financial Policies Agreement

This agreement supersedes all previous related agreements insurance.

If you have medical insurance, we are eager to help you receive maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your information to your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for you covered medical services to your insurance company, if your provider is considered in network. However we expect payment of all services rendered within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-– certifications, referral and authorization requirements. We will, however assist you to ensure that all plan requirements are met.

X _____ (please initial)

I understand that Loudon psychiatric care will file and attempt to collect from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges.

X _____ (please initial)

If your insurance coverage for your insurance carrier changes and you do not notify Loudon psychiatric care within 30 days of that change, Loudon psychiatric care reserves the right to not issue a refund. I agree to waive any insurance company policy rights that required refund of the aforementioned monies.

X _____ (please initial).

Payment for Services:

Full payment for services, including copayments and deductible amounts is due at the time of services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash and checks only. Our failure to correct collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and or expulsion from your insurance plan. In addition your failure to pay the required copayments is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or your insurance company representative

X _____ (please initial).

Failure to pay your co-pay at the time of service will result in a charge of $20 to help cover the additional administrative costs. You will be asked to sign a promissory note for the copayment amount plus the service fee.

X _____ (please initial)

Returned checks will result in a $50 fee that will be posted to your account. Returned checks, balances older than 60 days and failure to pay account balances as promised may subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt. Loudon psychiatric care has a “one bad check” policy. If your account has one returned check then you will not be allowed to write checks for future services
X _____ (please initial)

General:

we will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you not with your insurance company.

Note all services are a covered benefit in all contracts.

X _____ (please initial).

1. I accept financial responsibility for all clinical and administrative services provided by Loudon psychiatric care.
2. I authorize payments to Loudon psychiatric care for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic, if Loudon Psychiatric Care decides to file an insurance claim.
3. I authorize the release of any medical, mental health or other information necessary to process a claim with my insurance carrier if Loudon psychiatric care desires so
4. I understand that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed
5. Appointment fee being added to my account. If you are unsure of your balance you may call Loudon Psychiatric Care at (703) 542–3737.
6 In many cases, there is a need for us to exchange information with other parties such as other treating physicians. You agree to release your medical information to treating, covering physicians in the best interest of providing care and services to you.
7 Ancillary services, including exchange of information as in #5 are billable hours.
8 By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Patient’s Name: _____ ____ Date: _____

Signature: _____

Parent / Guardians name: _____ Date: _____

Signature: _____