

## **Insurance and Financial Policy Notification**

**Financial arrangements are an integral part of your medical treatment plan. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.**

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO BEING TREATED. WE ACCEPT CASH, LOCAL CHECKS, CREDIT OR DEBIT CARDS ONLY.

### **INSURANCE**

If you are insured with a health plan that we are contracted with, we will submit a claim on your behalf after your insurance benefits have been verified. We'll need a copy of your current insurance card and complete information regarding the insurance policy holder. If we are unable to verify your benefits, we require that you pay in full for your visit. We require payment of co-pays and unmet deductibles in full at the time of service.

If you are insured by a plan that we do not participate with, you will be required to pay in full for your treatment at the time of service. However, we will provide you with a copy of your bill so that you can submit it to your health insurance for consideration.

### **USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Unless we are a provider for your insurance, you are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

### **HMO PLANS**

If we are a contracted provider with your HMO plan, prior authorization is required and must be obtained before your appointment date. Please be sure to confirm with our staff that your visit has been authorized by your health plan prior to your treatment. If we are not contracted with your health plan, they will not pay for any of your treatment, and you will be responsible for payment in full at the time of service.

### **SECONDARY INSURANCE PLANS**

As a courtesy we will submit a claim to your primary insurance carrier for consideration. If you have a secondary policy that we do not participate with, we will provide you with an itemized statement for you to submit to your secondary plan. However, you are responsible for any unmet deductible and copayments at the time of service that are not covered by your primary insurance policy.

### **CONSENT FOR TREATMENT** (The undersigned authorizes each of the following statements.)

- I hereby authorize all treatment with Dr. Brian Taylor, Joyce Weckl, PMHNP, or Fernando Cervantes, PMHNP.
- I give authorization for payment of insurance benefits to be made directly to Dr. Brian Taylor, Joyce Weckl, PMHNP, or Fernando Cervantes, PMHNP .
- I understand that I am financially responsible for all charges incurred, whether they are covered by my insurance or not.
- I agree to pay all costs for collection and reasonable attorney's fees regarding the collection of any unpaid debt I incur.
- I authorize Dr. Brian Taylor, Joyce Weckl, PMHNP, or Fernando Cervantes, PMHNP to release all information necessary to secure payment of benefits.
- I certify the information I have provided is true and correct to the best of my knowledge.
- I understand that I must read and sign this Financial Policy before receiving treatment.

**I have read the Financial Policy, understand, and accept my financial responsibility.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Guarantor Signature (If patient is a minor)

\_\_\_\_\_  
Date