PSYCHIATRIC ASSOCIATES

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STATEMENT OF PATIENT REPONSIBILITY AND FINANCIAL POLICIES

Patient Name:_____ DOB: _____

1. You are responsible to pay for all services rendered.
2. In the absence of health insurance coverage, or if we do not accept your insurance plan, you are expected to pay for services before the time of your appointment. Likewise, your co-pay will also be due before your appointment.
3. You are responsible for calling your insurance company to determine what out-of-network benefits you have, if any.
4. You may be charged if Dr. Murphy is asked to complete various types of paperwork such as disability or FMLA forms, DMV forms, or letters to attorneys, the court, or any other professional.
5. **A 24 hour notice of cancellation is required or you will be responsible for payment in full of the cancelled or missed appointment. Insurance will not pay for this.**
6. I hereby give consent that should my account become delinquent, Psychiatric Associates is authorized to release my name, account balance, and any other information as required to my insurance company, collection agency, or an attorney for collection of my account.
7. I understand that account balances are due within 30 days of the date of statement. Any balance over 30 days will incur a $5.00 late fee each month thereafter. I agree to pay all service charges if my account becomes delinquent, and pay any collection expenses, including attorney costs, should any action be initiated on that debt.
8. The parent who signs this paperwork at the initial visit will be considered the responsible party for all patient balances.
9. **I agree to pay for checks returned for insufficient funds and accept that I will be charged a $50.00 fee plus the original amount of the check as written.**
10. As a courtesy, our office will give you the appropriate forms for you to file with your insurance; however, all balances are ultimately your responsibility.

Patient/Responsible Party Signature _____

Print Name _____ Date _____