Mindful Balance Psychiatry

Financial Information

Financial Responsibility/Release of Financial Information:

Payments are to be made and due before each session begins. I fully understand my financial obligation to this provider. I hereby authorize and request my insurance company to pay directly to this provider the amount due for services rendered to my dependent or me. I understand that I am responsible for all charges, regardless of Insurance coverage. I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to my dependent or me. I authorize this provider to release my financial information to my guarantor or a third party collection agency (in case further collection assistance is required).

Patient's/parent's/guardian's Signature _____ *Date*_____

Release to Contact Primary Care Physician:

I authorize this provider to contact and release any medical, mental health, or substance abuse information regarding my treatment to my Primary Care Physician.

Patient's/parent's/guardian's Signature _____ *Date*_____

Separate Charge for ALL Forms Not covered by Insurance:

I understand that I am responsible for payment for completion of all forms that are not covered by my Insurance company. I also understand that payment Is due before forms are completed. This includes, but is not limited to, disability forms, medical leave forms, life insurance forms, forms required for work or school, etc.

Patient's/parent's/guardian's Signature _____ *Date*_____

24 Hour Cancellation Policy:

If I need to cancel an appointment, I will give this provider a minimum of 24 hours notice and understand that if I fail to give a minimum of 24 hours notice, I may be responsible for the full charge of the missed appointment. In the evenings and on weekends, you may leave a message on our answering service, which will accurately record the date, and time you place the call.

Patient's/parent's/guardian's Signature _____ *Date*_____

Confidentiality of Patient Records:

Your patient records are the property of this provider and shall be treated as confidential. To insure quality record maintenance and patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in the strictest confidence (with the exception of those situations which we are required by law to report; subpoenaed by a court of law, suicidal plans (not just thoughts), homicidal plans (not just thoughts), suspected child abuse, joint custody, run away (by minor) etc.

Patient's/parent's/guardian's Signature _____ *Date*_____

PATIENT NAME _____ *BIRTHDATE* _____

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