Family Psychiatric Center LLC

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PROFESSIONAL OBLIGATION:

To give you a thorough mental health examination, a careful diagnosis and complete follow-up care.

To respect personal privacy and confidentiality. You will be asked to sign a Release of Information Form should we need to confer with anyone outside this office.

To provide an early notice of cancellation due to office scheduling changes that occur.

PATIENT OBLIGATION:

To provide us with complete and accurate demographic information such as address and phone number, providing updates as necessary.

To provide current insurance information.

To provide 24 hours notice if you are unable to keep a scheduled appointment. Patients will be charged and/or services terminated due to non-compliance for failure to keep appointments.

INSURANCE:

As a courtesy to you, Family Psychiatric Center LLC will file your claims to your insurance company. However, it is your responsibility to understand what services are covered under your mental health policy. If you have any questions regarding covered services, we urge you to contact your insurance company before the services are provided by calling the customer service number on your card. You will be responsible for any copay, coinsurance, deductible or any other charges not covered by your insurance. You will be responsible for reporting any changes in your insurance coverage, such as new insurance, changes in your plan, etc. If your insurance has not paid within 90 days, the balance will be transferred to your responsibility.

FINANCIAL RESPONSIBILITIES:

It is mutually understood that all charges made will be the responsibility of the patient. If the patient is a minor, the parent or guardian who brings the patient in will be responsible. Full payment on the account is expected at the time of service. We reserve the right to withhold further scheduling of appointments until payment is made.

A. **No Show/Late Cancellation Policy:** You will be charged a fee or services terminated for failure to keep appointments unless 24 hour notice is given. All previously scheduled future appointments will be cancelled. The fee must be paid in full before any other appointments can be made.
B. **Delinquent Accounts:** If your account should become delinquent you will be responsible for any collection fees, court costs and any legal fees that would occur in the collection process. Patient/Guarantor agrees that any legal action for collection shall be filed in courts of Howard County, Indiana.

STATEMENT OF CONSENT:

If you have any questions, please discuss them with the secretary before signing this statement.

I hereby agree to the terms of this office policy regarding my financial responsibility, which I have read and thoroughly understand.

Patient Signature _____ Date _____
Or signature of Parent/Guardian