Psychiatric Associates, PA.

Michas, Valentine & Gill

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

Payment for services is due at the time of service, unless prior arrangements have been made with our Insurance and Billing Department. You (not your insurance company) are responsible for full payment of our fees, co-payments, deductibles, non-covered services or services which your particular plan may determine to be "not medically necessary" or beyond what they determine to be their maximum allowable charges. Some of these fees may be limited if we have a contract with your insurance company. **It is *very* important that you find out exactly what behavioral health, mental health or psychological assessment services your insurance policy covers, any limitations involved and any authorizations required prior to your initial appointment**

As mental health providers, our relationship is with you, not your insurance company. While the filing of insurance is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered until the account is satisfied in full. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly in the management of your account.

APPOINTMENTS ARE CONTRACTED TIME. A FEE WILL BE CHARGED FOR ALL APPOINTMENTS WHICH ARE NOT CANCELLED TWENTY-FOUR HOURS IN ADVANCE OR FOR MISSED APPOINTMENTS. ANY UPCOMING APPOINTMENTS WILL BE CANCELLED UNTILL FEE IS PAID.

****THE FEE FOR ALL PROVIDERS IS $100; _____ (initials)**

If you have any questions about the above information or any uncertainty regarding insurance coverage, please contact our insurance and billing department Monday through Thursday, from 8:00 a.m. until 4:00 p.m. at: 850-862-3144.

I have read and do understand the above. By accepting services, I accept the fee charged as a lawful debt and promise to pay said fee as outlined above and to include the cost of collection, attorney fees, and court costs if such is necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Florida or any other state. I also understand failure to pay the fee may result in release of my name and other information during the fee collection process.

_____	_____	_____
Responsible Party	Witness	Date

_____

Printed Name

Psychiatric Associates, P.A.

Michas, Valentine & Gill

INSURANCE INFORMATION

Patient Name: _____ Date of Birth: _____

PRIMARY INSURANCE

Company Name & Address: Name of Policyholder: _____

_____ Policyholder DOB: _____

_____ Policy #: _____

_____ Group #: _____

SECONDARY INSURANCE

Company Name & Address: Name of Policyholder: _____

_____ Policyholder DOB: _____

_____ Policy #: _____

_____ Group #: _____

RELEASE AND ASSIGNMENT AUTHORIZATION

I, _____, authorize Psychiatric Associates, P.A., Michas, Valentine, and Gill, or any holder of medical or information about me to release to my insurance company or its representative any information needed concerning the examination or treatment rendered to me that is necessary to process an insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits directly to Psychiatric Associates, P.A. Michas, Valentine & Gill, or the provider rendering the service (if an assignment) or to the patient (if a non-assignment) in such amounts as may be reimbursable to the insured according to the provisions of the patient's contract on any bills for services furnished to me by Psychiatric Associates, P.A., Michas, Valentine, and Gill, providers. **I also understand that I am financially responsible for all charges whether or not covered by insurance.**

_____ _____ _____

Responsible Party Signature Witness Date