CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT - B

PAYMENTS

It is the policy of CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA (CAPP) not to file insurance claims unless required to do so by contractual agreement with my insurance provider. *CAPP is filing claims with my insurance company.* I will assign insurance benefits to CAPP, and I am responsible for my anticipated portion of the charges upon receipt of each monthly statement. Personal check, cash, MasterCard and VISA are accepted modes of payment.

Co-payments are due at the time of service. In the case of co-payments for child patients, parents may also choose to pay a retainer or authorize automatic credit card deductions.

I will make myself aware of and abide by the stipulations of my insurance benefits and any referral authorization issued by my insurance carrier. If my insurance does not provide the anticipated mental health benefits, I understand that I am responsible for all charges (including deductibles). Defaulted accounts will be sent to collection. When a balance becomes 90 days past due, interest may be charged @ 10% per month.

CANCELLATIONS

I may be charged for missed or cancelled appointments, depending upon my doctor's cancellation policy. I understand that CAPP will not file claims for missed or cancelled sessions, as insurance does not reimburse for these charges, and I am responsible for all such charges. (Consult your doctor about his/her policy.)

RELEASE OF INFORMATION TO FISCAL INTERMEDIARIES

I authorize CAPP to disclose information to my insurance company that is necessary for my claim to be processed. A photocopy of this authorization shall be as valid as the original.

FINANCIAL RESPONSIBILITY

The person who signs this financial responsibility agreement is responsible for payment on my account. If I wish to designate someone other than myself as the person financially responsible for my account, that person must sign the financial responsibility agreement.

In the situation of divorced or separated parents of a child patient, one parent must be designated as the primary financially responsible parent who will make payments on the child's account, with any division of payment decided privately between the parents.

I agree to notify CAPP of any changes in my account information, at which time a different Financial Responsibility Agreement may be required.

DUPLICATION OF BILLING STATEMENTS

Please save all billing statements for tax, insurance, and other purposes. A charge may be made for preparation of duplicates at $5.00 for monthly statements and $25.00 for statements covering more than a one month period.

If you have questions or concerns about any of these issues, we encourage you to discuss them with your therapist. Thank you.

I have read and agree to the above. I have received a copy of this agreement.

Signature: ____ Date: _____________________________

Relationship to patient: ___________________________________