Montes Psychiatric Center, P.C. Financial Policies

Patient Name: _____

Please read carefully and initial each section below:

_____ **FULL PAYMENT**
Full payment for copays and self-pay services are expected at the time of service unless prior arrangements have been made.

_____ **INSURANCE**
We participate in several major insurance companies and managed care networks. We will submit claims to your insurance carrier if you have given us all of the required information. We will attempt to determine your benefits by contacting your insurance company via phone or online. However it is your responsibility to familiarize yourself with your insurance benefits and verify if we are in or out of network with your policy.Please note that the information we obtain from your insurance is not a guarantee of your benefits or coverage and therefore we cannot guarantee that your services will be covered. In addition, please be aware that some and perhaps all of the services provided may be "non-covered" or deemed "not medically necessary" according to your policy. Regardless of the type of insurance coverage you have, you are ultimately responsible for paying your medical bills.

_____ **PRIOR AUTHORIZATION/REFERRALS**
It is the patient's (or the responsible party's) responsibility to make sure any referrals or authorizations required by your insurance company are in place prior to services. Payment for any appointment kept without a needed authorization in place is the responsibility of the patient.

_____ **MINOR PATIENTS**
The adult accompanying a minor to a visit and/or the legal parents/guardians are responsible for full payment and will be set up as the person who receives the bill. Montes Psychiatric Center will not be involved in negotiating between parents/guardians in disputes. Parents/Guardians are responsible for knowing their insurance benefits. If an adolescent patient arrives alone, please make sure that he/she has the required payment due. **We will not bill third parties or unattending guardians!**

_____ **BILLING PROCESS**
If your claim is denied, or processes with a patient responsibility the balance due for services will be your responsibility. You will be mailed a statement for any balances due. If we do not receive a response from your insurance carrier within 31-60 days, you will receive a statement and will need to contact your insurance carrier regarding payment. The balance due for any unpaid services is your responsibility.

_____ **CANCELLATIONS/ NO SHOW POLICY**
I agree to give 24 hours notice if I must cancel or reschedule my appointment. If I fail to do so, I understand that I will be charged $50 for that session.

_____ **RETURNED CHECK POLICY**
A $35 returned check fee will be charged for any returned check, and the patient will be responsible for any fees for collection of past due balances.

_____ **OUTSTANDING BALANCES**
I understand that Montes Psychiatric Center reserves the right to prohibit services to the patient if at any time a balance of $200 or more is accrued.

_____ **AUTHORIZATION OF PAYMENT**
I hereby authorize and direct payment of my medical benefits to Montes Psychiatric center for any services furnished to me by the staff. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ **COURT ORDERED EVALUATIONS (IF APPLICABLE)**
I understand that any court-ordered evaluations will not be released without full payment. We accept cash, credit cards, and personal checks. The report will only be released 14 days after the receipt of payment if made by check. I understand that these evaluations will not be submitted to insurance by Montes Psychiatric Center, P.C.

_____ **I understand the above Financial Policy and agree to the conditions of such.**

_____

Signature of Patient or Legal Guardian Date

MONTES
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