STANFORD PSYCHIATRY MEDICAL GROUP
854 Magnolia Ave, Suite # 201, CA 92789
Tel : 951-356-5414 Fax : 951-356-5494

FINANCIAL POLICY-CONTRACT AND CONSENT FOR EVALUATION & TREATMENT

Thank you for choosing SPMG, as your mental health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for service is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to your treatment.

INSURANCE CLAIMS:

Professional fee, payment your bill is considered a part of your treatment. SPMG will bill your insurance, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Co-payments are due and payable at each appointment. If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill. **You are responsible for obtaining any prior authorization for treatment from your insurance carrier.**

PATIENT FINANCIAL RESPONSIBILITY: First visit is charged $ 300.00 and subsequent visits $ 125.00 for 15-20 min sessions.

We accept cash, checks and credit cards.

PAST DUE ACCOUNTS:

Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement. Prolonged delinquency in payment will result in preparation of account to be sent to a collection agency. This may result in a discharge from the practice. There will be a $50.00 fee for returned checks.

METHOD OF PAYMENT:

A credit card is required as part of the contract for evaluation and treatment. This credit card will be charged for missed appointments and/or outstanding balances that are past due 30 days.

□ MasterCard Credit Card Number __ __ __ __- __ __ __ __- __ __ __ __- __ __ __ __

□ Visa □ AMEX Expiry date _____

□ Discover Signature _____

CANCELLATION/NO SHOW/RESCHEDULE POLICY:

It is essential you are on-time for your appointment and call at least 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or cancel without 24 hours notice will result in a full visit charge.

RECORDS:

Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or patient's parents) release of information form. Record are sent at a fee of $25 including postage and billed directly to you. Please allow two weeks for this request to be processed.

HIPAA/ PRIVACY ACT:

Your signature below acknowledges that you have been provided a notice of your privacy rights per HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, the full text of which is available at www.hhs.gov/ocr/hipaa/. Your signature also acknowledges that you are aware of the qualifications of your doctors, their regulatory agencies to whom you may file a complaint, and general rules about confidentiality and appropriate professional behavior.

ACKNOWLEDGEMENT OF RECEIPT: I have reviewed the financial policy, and I accept financial responsibility of collection.

NAME (PRINT) _____ SIGNATURE._____DATE_____