

Thank you for choosing Arkansas Psychiatric Clinic as your health care provider. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please ask if you have any questions about our Financial Policy, fees, or your responsibility.

Insurance Coverage

Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated coinsurance and deductibles prior to seeing the provider.

In the event we accept assignment of benefits, the patient is still ultimately responsible for all charges.

Usual and Customary Rates

Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

Nonpayment

If your account is past due, you will receive a bill and the payment is due at that time or must be paid before you are seen back at the clinic. If payment isn't received for the past due balance then you may not be able to be seen at APC.

Missed Appointments

The clinic may charge \$50+ (or more depending on frequency of missed appointments) for appointments that are not kept or canceled with less than 24 hour notice. This policy will apply once you have missed or canceled with less than 24 hour notice following initial appointment with this clinic.

Paperwork Completion

The Doctor you see at APC reserves the right to deny paperwork completion requests. The clinic may charge a nominal fee for the completion of paperwork. This charge will vary. Clinic policy requires that a paperwork completion form be filled out at the time of request. Please allow up to 10 business days from the date of this request for us to complete this.

Assignment of Insurance Benefits

I request that payment of insurance benefits be made on my behalf to **Arkansas Psychiatric Clinic** for any services furnished to me by any provider in this clinic. I authorize any holder of medical information about me to release my information needed to determine benefits to my insurance carrier, and where applicable, to the Center for Medicare and Medicaid Services and its agents. I further authorize the clinic or its agents to verify employment date and wage data in the event collection action becomes necessary.

Signature of patient or responsible party

Date

Signature of co-responsible party

Date

We accept cash, check, Visa, Mastercard or Discover