



MARIETTA PSYCHIATRY ASSOCIATES PC
670 North Ave NW, Suite 200,
Marietta, GA 30060-1100
Phone: 770-678-7034 Fax: 770-678-7035

FINANCIAL POLICY

Authorization to Treat: I authorize MARIETTA PSYCHIATRY ASSOCIATES PC to render and administer all necessary treatment and procedures to my child. I understand that the accompanying adult is to be assumed by MARIETTA PSYCHIATRY ASSOCIATES PC to be the parent or legal guardian, or an authorized adult having permission by the parent or legal guardian to seek medical care and attention for the child, and it is assumed that sharing of Protected Health Information has been granted by the parent or legal guardian to the accompanying adult by the child's parent or legal guardian.

Authorization to Release Information and Assignment of Benefits: I authorize the sharing and release of any information acquired during the treatment of my child for the purpose of processing insurance claims, and obtaining payments and imbursements.

Authorization of Payments to the Physician and Marietta Psychiatry Associates PC LLC: I authorize payment directly to the physician and to MARIETTA PSYCHIATRY ASSOCIATES PC for any medical and surgical services rendered. I understand that I am directly responsible for payment of co-payments, coinsurances, deductibles and other fees that are covered and/or not covered by my child's insurance carrier.

Insurance Plan: I understand it is my responsibility to be aware and knowledgeable of my child's insurance plan benefits, coverage, and policies. I understand this includes and is not limited to well- visits, preventive care, physicals, sick visits, laboratory tests, radiology, immunizations, and out-of- network services. I understand it is my responsibility to check with my child's insurance carrier that my child's physician is under contract and in-network with the insurance carrier. I understand that if the physician is out-of-network, I am agreeing for my child to be seen by the physician as an out-of- network provider, and all co-payments, coinsurances, deductibles and fees that are covered and/or not covered by the insurance plan is my responsibility for payment.

Pre-authorization/Pre-certification: Some insurance companies require pre-certification/pre-authorization. We will gladly assist you in meeting these requirements when requested, however, the responsibility is yours to ensure that any such requirements are complete prior to the treatment. If pre-certification/pre-authorization is

required, and not completed, you will be responsible for all denied charges.

Payments: All co-payments, coinsurances, deductibles and fees are due in full at the time of service. As a courtesy, we will file your insurance claim for you. If your insurance company does not respond or pay within a reasonable length of time (60 days), you will be expected to follow up with your insurance company. In that case, you are responsible for any amount that your insurance does not pay within the 60-day period.

Updated Insurance and Account Information: It is your responsibility to inform us of any changes on your or your child's account regarding insurance or address information. Acceptable insurance identification is required if there is a change in insurance companies or insurance coverage. We will require to keep a scanned copy of your new insurance card once you receive it.

Cancellations and No-show Fees: There is a \$50 charge for cancellations and rescheduling less than 24 hours from appointment time, and for no-shows to appointments that were not cancelled or rescheduled. An appointment missed by one, is an appointment missed by two as someone else could have used that appointment. We will see patients who are no later than 10 minutes late. Patients arriving later than 10 minutes will be triaged for severity of complaints and be accommodated accordingly. It is best to call and let us know if you are going to be late.

Credit Card on File: MARIETTA PSYCHIATRY ASSOCIATES PC requires an active and unexpired credit card to be kept on file at all times. The credit card will be used for payments for medical services rendered, for account balances, and for cancellation, late rescheduling, and no-show fees charged as per our policy. This credit card on file will only be used if your balance is not paid in full in 120 days. You will also need to sign a patient payment consent form. You will be notified in writing of any charges made to your credit card. The credit card information will be securely filed in an encrypted format to prevent theft.

Returned Checks: Checks returned and payments refused for insufficient funds will be charged \$50 service fee.

If You Do Not Have Insurance: A minimum deposit of \$250 or the actual charges, whichever is less, is due at the time of the service for all self-pay patients. Any subsequent visit charges will be due at time of service. If you cannot pay in full, we will advise to set up a payment plan by speaking to someone in the billing office. The parent or guardian accompanying the patient is responsible for payments.

Collections: It is our policy that our past due accounts will be sent two statements, and thereafter one phone call will be made to try to make payment arrangements. If payments are not made to the patient account, the account will be sent to the collection agency. Please note that after your balance has been sent to collection, you may be

dismissed as a patient in our clinic. Your balance will need to be paid at our collection agency in full prior to receiving services in our clinic. In the event that your account is placed with a collection agency, a collection fee of up to 33.3% may be added to your account and shall become a part of the total amount due. You will be responsible for any and all cost of collection including attorney fees and court costs. The practice will do its best to work with our families to meet payment obligations.

After Hours Triage Calls: For medical concerns after-hours, and on weekends and holidays, In case of an emergency, please go dial 911 or go to the nearest emergency room. All non-emergency calls will be directed to voicemails which will be reviewed and calls will be returned the next business day..

Forms: Health forms will be completed on the day of the appointment. Any requests for forms to be completed after the appointment will carry a \$20 fee. For more detailed forms such as the FMLA, a \$40 fee will be applicable.

ACKNOWLEDGEMENT

I have reviewed the Financial Policy of MARIETTA PSYCHIATRY ASSOCIATES PC and agree to all its terms.