Palmetto Behavioral Health Solutions
Very Important Financial Information

Please read and initial all of the following:

<u>Provide Complete and Accurate Information</u>

_______ You will be asked to review your patient data once per year. We may have you complete a new registration should there be pertinent information changes. We begin this process in March each year. It is imperative that we have the most current information on file for you. Otherwise your insurance company may not cover services for you and you may be liable.

<u>Cancellation of Appointments</u>

_______ We require 24 hour notice if you wish to cancel an appointment with our providers. We request this advanced notice so that we may schedule another patient in your place. Appointments missed or canceled with less than a 24 hour notice are subject to a $75.00 fee. This fee will be billed directly to you. Your insurance company will not cover this fee. ***As well as incurring a fee for inadequate notice, continued missed appointments may result in discontinuation of services with this practice.***

<u>Method of Payment</u>

_______ We accept Cash, Checks, Visa, MasterCard. We do not "hold" checks. Our checks are automatically debited from your account.

_______ We will charge a $32.50 fee for returned checks. In addition to this charge, should you have more than one check return from the bank, we will no longer be able to accept checks as payment.

<u>Payment Information</u>

_______ Payment of Patient Portion is required at the time of service. ***This includes Copays, Coinsurance, Deductibles and any other patient portion***. Should you have special circumstances that hinder the payment for services, we may be able to develop a payment plan to suit your needs.

_______ If we are a participating provider with your primary insurance company, we will require a copy of your insurance card at the time of registration as well as if your insurance plan changes. This ensures the accuracy of our insurance information so that there is less chance of insurance denial, which may result in a bill to you. If your insurance requires a co-payment, co-insurance, or if your deductible has not been met, you will be expected to meet those obligations at the time of service.

_______ If we are not a participating provider with your insurance company, if you do not have insurance coverage, if we do not have verifiable insurance information on file for you, or if you are not able to produce your insurance card for verification, you will be responsible for payment for services rendered. ***We do not file secondary insurance for out of network plans***.

_______ If we are a participating provider for your insurance, we will file your insurance as a <u>courtesy</u> to you, but ***it is your responsibility to know and understand your insurance coverage***.

_______ If we ARE NOT a participating provider with your insurance company, we will file your primary policy as a courtesy to you. However, if payment for services is not received within 90 days, the balance will then become patient liability.

_______ Failure to notify us of insurance changes may result in a bill to you. If we don't have verifiable insurance information, we cannot bill your insurance company. Also, many insurance companies require a precertification for services. If we are not made aware of policies you may have that might require this certification, we cannot bill your insurance company.

_______ Failure to make adequate payment on your account may result in termination of services.

<u>Other Possible Non-covered Services</u>

_______ If you request copies of any part of your medical record for release to you, there will be a charge for copying these records. The charge for this is regulated by SC Law. There is a flat $15.00 charge plus a per copy charge of 65 cents.

_______ If your doctor is requested to complete any Disability Determination paperwork, there is a $25.00 fee for this service.

_______ If you request that your outside records (if extensive) be evaluated by your provider here, there will be a charge of $20.00 billed to you.

By initialing each of the above points of the financial policy and signing below, I acknowledge I have received and understand my financial responsibilities as a patient of Palmetto Behavioral Health Solutions.

_______________________________	_______________________________
PRINT PATIENT NAME	Patient/Responsible Party Signature
_______________________________	_______________________________
Witness	Date

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