SUMMERVILLE PSYCHIATRIC ASSOCIATES

FEES FOR SERVICES

Insurance

As a service to patients, we will submit claims to your insurance company. I understand I am responsible for all payment obligations arising from my treatment or care and guarantee payment for these services. I understand I am responsible for deductibles, co-payments, co-insurance amounts, or any other patient responsibility indicated by my insurance carrier or Summerville Psychiatric Associates' Policies, which are not otherwise covered by supplemental insurance.

I understand I am responsible for understanding my plan limitations including deductible, co-payment, co-insurance, out-of-network, prior authorization requirements, or any other type of benefit limitation before receiving services. I understand any benefits quoted by my insurance company are estimates and cannot be guaranteed until my claims have been processed.

I understand payment is due at the end of each session. I understand I am responsible for notifying administrative staff of any changes in my insurance or demographics and I am responsible for any financial obligations that result from these changes.

Our providers are each independently contracted with various insurance companies. To check if your provider is in-network with your plan, you will need to provide the provider's name, not Summerville Psychiatric Associates.

Authorization to Release Information

I authorize my mental healthcare provider to release information about me to my insurance company and the Professional who referred me. This information is protected under the Privacy Act, the Drug Abuse Office and Treatment Act, and the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act.

Minor Patients

I understand parents/guardians of a minor are responsible for payment of the minor's account balance. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Summerville Psychiatric Associates.

Psychological Testing Services

Psychological testing fees include the time spent with you, the time needed for scoring and studying the test results, and the time needed to write a report on the findings. The amount of time involved depends on the tests used and the questions the testing is intended to answer. I understand I will need to discuss any psychological testing and fees for the services with us in advance and agree to pay any fees that occur.

Reports

You will not be charged for time spent doing routine reports to your insurance company. However, I understand I will be billed for any extra-long or complex reports the company might require. This includes the completion of any company disability insurance forms or Employee Assistance forms. I understand that insurance does not cover these expenses and agree to pay any fees that occur.

Other Services

Charges for other services such as consultations with other therapists or any court-related services (such as consultations with lawyers/guardian ad litems, letters to attorneys/guardian ad litems about your case, depositions, or affidavits) will be based on the time involved in providing the service. Some services may require payment in advance. These fees must be discussed before services are provided. I understand that insurance does not cover these expenses and agree to pay any fees that occur.

Court/Legal Fees

I understand if my provider is subpoenaed to testify in court or give a disposition, I will be charged additional fees for that time. These fees are determined by the provider and are separate from the regular fees for sessions. Fee schedules are available upon request. I understand that insurance does not cover these expenses and agree to pay any fees that occur.

Billing Statements

I understand when I receive a billing statement, the payment due is expected to be paid within thirty (30) days of when I receive it. I understand if any balance on my account is over ninety (90) days past due, my account will be in default and may be auto-referred to a collection agency.

For small balances, between $0.01 to $25.00, we may stop sending billing statements any time after the initial statement. I understand the amount shall remain due and owing until paid in full.

Payment is accepted by check, cash, money order, debit card, or credit card. Payments may be made in person, by mail, or by calling the number provided on the billing statement.

I understand I will be charged an additional $35 for any check returned by the bank.

Non-Payment on Account

I understand if my unpaid balance reaches $150, services may be suspended until payment is brought up to date.

Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, I understand that Summerville Psychiatric Associates has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I understand I am responsible for all costs of collection including, but not limited to: (i) late fees, charges, and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under a separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. I acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on my account, and is not deemed interest as part of a credit transaction.

If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

BY SIGNING BELOW I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Name (Print): _____

Signature: _____ Date: _____

Patient Name (if different from above): _____