Psychiatry Associates of Kansas City, P.A.

Authorizations and Financial Policies

Patient's Name: _____ **MRN:** _____

_____ ITEM 1 – Assignment of Insurance Benefits

Initials I hereby authorize & assign, my insurance carrier(s), to make payment directly to Psychiatry Associates of KC (PAKC) of insurance benefits. PAKC files both primary & secondary insurance as a courtesy to patients. I understand & agree that I am financially responsible to PAKC for ALL charges incurred regardless of potential insurance benefits, including but not limited to co-payments, co-insurance, deductibles, pre-existing & non-covered services. I understand PAKC will not become involved in disputes. I understand it is my responsibility to verify with my insurance company the physician treating me is covered under my insurance & to get referrals & /or authorization for services.

_____ ITEM 2 – Requirements at Time of Service

Initials I understand insurance cards must be presented at time of service or the account will be Self Pay. If insurance changes within treatment, cards must be presented prior to PAKC filing claims to new insurance company. If cards are not presented prior to the timely filing deadline, I will be responsible for payment. If an authorization had to be obtain, I will be responsible since the card was not presented at time of service. Co-payments & balances are due at time of service.

_____ ITEM 3 – Minor Patients **(Patients under age 18)**

Initials Any patient under the age of 18 must be accompanied by a patient/guardian to the initial visit. I understand by signing PAKC's financial policy, I am solely responsible for any incurred charges for the patient named below. Patients under the age of 18 may not cancel or change an appointment.

_____ ITEM 4 – Returned Check Fee

Initials I understand if PAKC receives a returned check for any reason, I will be charged an additional $30.00 & could be changed to a cash only basis thereafter.

_____ ITEM 5 – Terminating & /or Discharging Patient Treatment

Initials I understand PAKC has the right to terminate/discharge any patient from this practice at anytime due to but not limited to treatment non-compliance, abusive behavior/language, failure to pay & /or failure to show for scheduled appointments.

_____ ITEM 6 – Appointment Reminders

Initials I understand PAKC may call the patient's home by computer before the appointment to confirm the appointment's date & time; this is only a courtesy. If you do not wish to be contacted, please let the office know that you are declining this service. You may be billed for appointments not cancelled prior to 24 hours. If you are late, the physician may cancel your appointment.

_____ ITEM 7 – Prescriptions

Initials I understand that I will request any needed renewal of prescriptions during the time of my appointment with the physician. In general, you will be provided enough refills to last until your next expected appointment. If you do require refills between appointments, please notify your pharmacy and they will contact us. **Prescriptions for controlled substances cannot be called in and will require a written prescription. It is your responsibility to notify our office seven days in advance if you are in need of a prescription. Failure to make follow-up appointment as directed by the doctor, or missing a scheduled appointment, or losing a prescription may result in a prescription fee or denial of refills until seen**. Prescriptions may be picked up during business hours, Monday through Friday 8:00am to 5:30pm, after you have been notified they are available.

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to us. Please ask if you have questions about the information in the financial policies. All patients must complete our "patient information" form & sign the financial policy in order to be seen in this office.

Signature _____ Initials _____ Date _____

Guardian or
Other Resp. Party _____ Initials _____ Relationship_____