# PSYCHIATRIC SERVICES, P.C.

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## TREATMENT AGREEMENT

- I consent to the care and treatment for myself with Drs. Jones, Sedlacek, McGivern, Buda, Lubberstedt and their associates.
- I understand that I am financially responsible for all charges incurred for the services received from the above providers, regardless of insurance coverage. This includes, but is not limited to charges that are denied for pre-existing conditions, usual and customary allowances, and charges not allowed / covered by the insurer. Because of the growing number of different insurance policies, it is my responsibility to check and become familiar with my mental health benefits. Furthermore, if my managed care plan requires precertification, I realize it is my responsibility to precertify my first visit and present my authorization number at the time of my first visit. I understand the business office will cooperate with my insurance company, but that it is my responsibility to contact my insurance carrier to meet any additional requirements for pre-certifications that are not listed above.
- I have been informed that my insurance company may request copies of my medical records be faxed in order to make payment or authorize further visits. My signature below gives my permission to release this information and to fax medical records when requested.
- I understand the physician/therapist cannot render services on my behalf on the assumption that the charges will be paid by my insurance carrier. I further understand that in the event of non-payment by my insurance carrier for any reason I agree to be personally responsible for the balance. In the event of non-payment, my account may be assigned or referred to a collection agency for collections.
- I understand and agree to the terms of the Credit Policy as outlined below:
  Payment is expected in full within 30 days from your statement date. Limited exceptions may be allowed but only if prearranged. My copayment, coinsurance and any deductible is expected at the time of service.
- I am aware that the effectiveness of the treatment reviewed with me depends upon my commitment to the program and follow through with scheduled appointments. If I do not give 24 hours notice of cancellation there will be a charge for that missed appointment. Also, if repeated appointments are missed this may result in termination of care from this office and/or referral to another provider.
- I agree to provide timely notification to Psychiatric Services, PC of any changes in address, guarantor status, employment, and insurance coverage.
- I understand that I may use my VISA, Mastercard, Discover, American Express or bank debit card to pay for my services.
- I understand it may be necessary from time to time for the office to contact me by telephone. If I cannot be reached, I understand the office policy is to leave a discreet message on my answering machine or voice mail, or with whomever answers the telephone on my behalf. I agree to hold the office harmless for all such disclosures in compliance with this policy.
- No recording of any patient sessions shall be allowed and no recording devices of any kind shall be brought by a patient to a session.
- My signature below indicates I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____

**Signature of Patient and/or legal guardian**

Date _____ Witness _____

Submit