

Name: _____

DOB: _____

SS#: _____

Pembroke Center for Wellness Inc.

FINANCIAL POLICY

Thank you for choosing Pembroke Center for Wellness as your mental health provider. We are committed to your emotional health and well being. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the assigned provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We accept: Cash, Personal Checks, Debit Cards, MasterCard, Visa, American Express, Discover and Money Orders.

Regarding Insurance: You agree that we will accept assignment of insurance benefits, however, we do request deductibles, co-insurance and co-payments to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company, we will require a pre-approved payment plan or a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account with 30 days, you will be requested to call them to have your claims processed. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. By signing below you give us permission to bill your insurance company for all services provided by us, and accept assignment of these benefits to Pembroke Center for Wellness, and provide the insurance company with any documents they request to facilitate the payment of your claims.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. If you are here for Psychological Testing and you wish to have your test results expedited there will be a \$50.00 cash fee that will be paid at the time the results are released.

Minor Patients: Minors (for purposes of this paragraph, minors are those persons under the age of 18) will not be seen unless (a) accompanied by a parent or guardian, (b) we have a pre-authorized payment agreement, (c) under certain specific mental health treatment plans required by law. The parents (or guardians) are responsible for the payment of services provided.

Missed or Late Cancelled Appointments: Unless cancelled 24 hours prior to your appointment, our policy is to charge for missed or late cancelled appointments at the rate of \$35.00 for counseling appointments. If the appointment was for Psychological Testing the rate will be \$35.00 per hour. If three or more appointments are missed or late cancelled, you may be required to obtain services from another provider. Please help us serve you by keeping your scheduled appointments.

Check Policy: A \$35.00 return check fee will be assessed to your account for every check returned to Pembroke Center for Wellness for insufficient funds. Patients who issue two checks that are returned for "non-sufficient funds" will be required to make all payments by cash, money order, credit or debit card.

Collections Policy: We reserve the right to turn any patient over to a collection agency if it is deemed that the account is in default of payment obligations or for noncompliance with this policy. Should your account be turned over to a collection agency, you will be responsible for all fees charged to Pembroke Center for Wellness to include, but not limited to Attorney's Fees, Court Costs, Interest of 1.5% per month, a statement fee of \$3.00 per mailed statement, and any fees charged by the collection agency to process your account, in addition there will be a \$35.00 collection fee due to extra processing by our staff. Patients who have previously been in collections will be required to pay old balances in full for all future visits at the time of service. Patients who do not comply with this policy may be dismissed/discharged from the practice. Only emergency care will be provided for a 30 day grace period following dismissal from the practice. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Print name of Client/ Guardian

Signature

Date