Cedar Valley Psychiatry
8130 Adams Drive, Hummelstown PA, 17036

PATIENT NAME_____ DOB _____/_____/_____

FINANCIAL AGREEMENT

I understand that all professional services rendered will be charged to the above patient. I agree that I am financially responsible for those services. **I understand that although Cedar Valley Psychiatry may assist in processing my claims, it is my responsibility to assure that any insurance coverage I have, is current, and will reimburse for services provided. In addition, I will be responsible for any amount not covered by my insurance.**

I authorize Cedar Valley Psychiatry to bill my insurance company and provide them with any medical or other information necessary to process claims for reimbursement for services and service dates. I also request payment of insurance to be made directly to Cedar Valley Psychiatry.

I authorize Cedar Valley Psychiatry to provide any health information (medical/psychiatric/psychotherapy notes) to my health insurance providers in case of an audit or financial review of my health record (coding/diagnoses/services/billing) requested by them.

SIGNATURE _____ DATE _____

PRINTED NAME _____

Office Payment Policy (For all patients to read and initial each paragraph)

I understand that payment is expected at the time of service, unless other arrangements have been made in advance. All copayments, regular coinsurance payments and deductibles will be collected at the time of service by check, cash, and all major credit cards or debit cards. **(Initial here) _____**

I understand that I will be charged for any appointment that I schedule and do not keep, unless I cancel that appointment at least 2 Business Days prior to that scheduled appointment. My charge for a missed appointment will be a service fee of $30.00. **(Initial here) _____**

If the patient does not follow the recommended treatment plan, which may include, scheduling and keeping appointments, following doctor and therapist recommendations, and making payments, the clinician may need to discharge the patient. (This may include, but is not limited to the patient not showing for 2 or more sessions, or canceling 2 consecutive sessions, but is at the discretion of the clinician.) **(Initial here) _____**

All medical record requests for patients will be processed with a signed release of information from Cedar Valley. A flat fee of $20 will be charged for medical record request. (In the event that any record is more than 25 pages subsequent fees will be assessed.) Records will not be released until payment is made. **(Initial here) _____**

I understand that a return check fee of $25.00 will be charged for any returned checks. **(Initial here)** _____

Cedar Valley reserves the right to access credit data for the purposes of granting credit and/ or collections of any account. I will be responsible for any attorney or collection fees incurred in the collection of any balance owed. **(Initial here) _____**

PRIVATE PAY (please complete only if we do not accept your insurance)
I understand that Cedar Valley Psychiatry does not accept my health insurance at this time. I will be paying for services out of pocket.
SIGNATURE_____DATE _____

By signing here, I agree that I have read and will abide by Cedar Valley's financial policy in its entirety. I have had the opportunity to ask questions and discuss any concerns.

SIGNATURE _____ DATE ____/____/____