FINANCIAL POLICY

We are committed to providing you with the best possible care. We request your assistance and your understanding of our payment policy.

PAYMENT

Copayment for services is due at the time services are rendered if we are contracted with your plan. We accept cash or personal checks. There is a $15 administrative fee for copays not paid at the time of service. Since each health plan has varying mental health copayments, we encourage you to check your own policy. There are some plans where we are able to quote an exact amount. Otherwise, we must wait until your plan processes our bill to settle up with you. Please pay the estimated amount the receptionist requests until that determination has been made. For patients who do not carry an insurance plan with which Dr. Brink contracts, payment in full is expected at the time of service.

CANCELLATIONS

You will be charged for scheduled appointments not canceled with at least 48 hours advance notice. In addition, you will be charged for failed appointments. Insurance companies will not pay for missed appointments or late cancellations.

INSURANCE

Your insurance is a contract between you, your employer, and the insurance company. Not all services are covered benefits in all insurance contracts. Your doctor will assist you in determining whether continuing care will be authorized. Your evaluation will be covered if you are eligible for insurance coverage at the time you come for initial care and if your primary care doctor has obtained the proper authorization.

If you have any questions about our financial policy or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

****

I have read and understand the above financial policy. I understand that I am financially responsible for copayment for services rendered if eligible for insurance at the time I receive service. If it is determined that I am not eligible for insurance coverage, I understand that I will be personally responsible. For plans with which we do not contract, payment in full is my responsibility.

In addition, my signature below authorizes the release of information pertinent to my care, if requested by the company in order to cover services. I authorize payment of any insurance benefits directly to the provider of service.

_____ _____

Signature Date