Insurance and Financial Policy Notification

Financial arrangements are an integral part of your medical treatment plan. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO BEING TREATED. WE ACCEPT CASH OR LOCAL CHECKS ONLY.

INSURANCE
If you are insured with a health plan that we are contracted with, we will submit a claim on your behalf after your insurance benefits have been verified. We'll need a copy of your current insurance card and complete information with regard to the insurance policy holder. If we are unable to verify your benefits, we require that you pay in full for your visit. We require payment of co-pays and unmet deductibles in full at the time of service.

If you are insured by a plan that we do not participate with, you will be required to pay in full for your treatment at the time of service. However, we will provide you with a copy of your bill so that you can submit it to your health insurance for consideration.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Unless we are a provider for your insurance, you are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

HMO PLANS
If we are a contracted provider with your HMO plan, prior authorization is required and must be obtained before your appointment date. Please be sure to confirm with our staff that your visit has been authorized by your health plan prior to your treatment. If we are not contracted with your health plan, they will not pay for any of your treatment and you will be responsible for payment in full at the time of service.

SECONDARY INSURANCE PLANS
As a courtesy we will submit a claim to your primary insurance carrier for consideration. If you have a secondary policy that we do not participate with, we will provide you with an itemized statement for you to submit to your secondary plan. However, you are responsible for any unmet deductible and copayments at the time of service that are not covered by your primary insurance policy.

CONSENT FOR TREATMENT (The undersigned authorizes each of the following statements.)

I hereby authorize all treatment with Dr. Brian Taylor and/or Joyce Weckl, PMHNP.
I give authorization for payment of insurance benefits to be made directly to Dr. Brian Taylor or Joyce Weckl PMHNP.
I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance.
I agree to pay all costs for collection and reasonable attorney's fees with regard to the collection of any unpaid debt I incur.
I authorize Dr. Taylor and/or Joyce Weckl to release all information necessary to secure payment of benefits.
I certify the information I have provided is true and correct to the best of my knowledge.
I understand that I must read and sign this Financial Policy before receiving treatment.

I have read the Financial Policy, understand, and accept my financial responsibility.

____ ____________________
Patient Signature Date

____
Patient Name Printed

____ ____________________
Guarantor Signature (If patient is a minor) Date

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. It is our intent to avoid any confusion or problems related to providing you with the best care possible.