NW PSYCHIATRY FINANCIAL AGREEMENT

I acknowledge that insurance will be billed on my behalf. I understand that my insurance policy is a contract between myself and my insurance. I understand that any negotiating of payments or denial of payment by my insurance for whatever reason, is my responsibility. It is my responsibility to know my insurance information (copays, deductible, coverage etc.) I am ultimately responsible for any balance of my account. **Initial_____**

I assign medical benefits paid by my insurance carrier to Dr. Salbador, for the application of my bill. I understand that I will be billed for charges not covered under my insurance policy.

If my insurance carrier refuses payment, I agree to pay for all services upon receiving written and/or verbal notice of the denial. After my insurance has processed the claim, I understand that a $25.00 rollover fee will be added to my account monthly until paid. If my account becomes delinquent after 90 days, the account balance will be forwarded to collections. Failure to contact our office regarding your balance will be documented. **Initial_____**

All copays or self-pay fees MUST be paid on the day of your appointment. **Initial_____**

If you are a self-pay patient and do not pay for your visit at the time of service or day of service, you will be charged the full price of the visit. We are only able to offer the time of service discount *if* paid on the day of your appointment. Our staff will reach out to collect payment. If they are unable to reach you, please call the office to make your payment on the day of your appointment. It is your responsibility to make sure this is collected. **Initial_____**

Returned/NSF checks will incur a $35 fee.

If we are out of network with your insurance company, you may request a Single Case Agreement through your insurance provider. Single Case Agreements are to be requested and set up by the patient and are up to you to initiate the process. These must be renewed yearly (or whatever timeline your insurance determines) for them to remain in effect.

In the unfortunate circumstances that I do not pay for services provided to me when due, I understand that my account will be sent to collections. I agree to pay all costs associated with collection, including any fees associated with the collection process. At this point, I will also be notified that Dr. Salbador will only be able to provide care and medication management for 30 days and I will be asked to find another provider.

**I have read and understand NW Psychiatry's Financial Agreement and I agree to be bound by these terms. I understand my financial responsibility for all care rendered to me as long as I am a patient of this practice.

Print Name:_____

Sign:_____ Date:_____