



**PSYCHIATRIC ASSOCIATES OF NORTH CAROLINA, P.A.**  
**FINANCIAL POLICY**

Thank you for choosing us as your psychiatric provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

*All patients must complete our INFORMATION FORMS before seeing the doctor. FULL PAYMENT is due at time of service. We accept cash, checks, visa or MasterCard.*

**REGARDING INSURANCE:**

Our policy varies according to type of insurance. Unless your insurance is one in which we accept co-pays, we require payment in full at time of service. You will be given a receipt in which you can file the insurance. If we are not a contract provider with your carrier, you are responsible for full payment. Deductibles will deny claims. If you have a calendar year deductible, you are responsible in paying each visit in full until you have met that obligation with the carrier. Co-payments are to be paid each visit. Please notify the office if you have a change in coverage. Authorizations for your first visit are your responsibility.

**USUAL AND CUSTOMARY RATES:**

Our practice is committed to providing the best treatment for our patients, and we charge the usual and customary rate for our area. You are responsible for payment, regardless of any insurance companies arbitrary determination of usual and customary rates or non-charges.

**MISSED APPOINTMENTS:**

Unless cancelled, at least 24 hours (business day) in advance, our policy is to charge the normal office visit rates, as your insurance will not pay for missed appointments. We do try to call you a day prior to confirm your appointment, but please realize that this is only a courtesy call. You are ultimately responsible for remembering your appointment day and time. Please help us serve you better by keeping your appointments.

**STATEMENT OF ACCOUNTS:**

Each visit, your check out receipt will show whether there is a balance due. Insurance sometimes take a while to collect. The office staff will notify you at your visit if there is a balance due.

Please let us know if you have any questions or concerns. I have read the policy and agree to the terms.

\_\_\_\_\_  
\_XXX\_ (Signature of Patient or Responsible Party) \_\_\_\_\_ DATE \_\_\_\_\_  
\*\*\*\*\*

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**SEE COPY IN OFFICE LOBBY**

**\*\* You May Refuse To Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read or received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
\_XXX\_ {Signature}

\_\_\_\_\_  
{Date}

**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- \_\_\_ Individual refused to sign
- \_\_\_ Communications barriers prohibited obtaining the acknowledgement
- \_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_ Other (Please Specify)