Child, Adolescent & Adult Psychiatry

17 Arcadian Way, Paramus, NJ 07652
Phone: 201-977-2889 Fax: 201-977-2890

FINANCIAL POLICY

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 you to read and sign prior to any treatment.

Patient Name: _____ Date of Birth: _____

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. We accept cash and credit cards.

FOR PATIENTS WITH Medical Insurance Policies:

We do not participate on the panels of any Medical Insurance carrier plans. If you believe that your Medical Insurance carrier will cover some or all of your visits, please contact your medical insurance carrier prior to your first visit to verify out of network coverage and deductibles.

If your Medical Insurance carrier covers out of network benefits, we will provide you an invoice after each visit, that can be submitted to them for reimbursement.

Payment in full is due at the time of each appointment and will be collected prior to the appointment.

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

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. Monday appointment cancellations must be received by the previous Friday. You will be charged the full session fee for missed appointments. Repeat missed appointments can result in dismissal from the Practice.

I have read, understood and agree to the above financial policy for payment and professional fees, as well as managed care referrals and medication refills protocol.

The patient is ultimately responsible for all professional fees.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

_____	_____	_____
Please Print Name	**Signature of patient or responsible party**	**Date**

Relationship, if minor: _____