Child, Adolescent & Adult Psychiatry

17 Arcadian Way, Paramus, NJ 07652
Phone: 201-977-2889 Fax: 201-977-1548

FINANCIAL POLICY – Personal Injury Patients

Patient Name: _____ Date of Birth: _____

Charges for services incurred as a result of an automobile accident will be treated as a Personal Injury claim. You must provide necessary information to bill the carrier. We will bill the Auto Insurance carrier as a courtesy.

Initial **x_____ If the Auto Insurance carrier determines that your condition is not as a result of your automobile-related injury, or your claim is denied for other reasons, you will be required to PAY ALL AMOUNTS DUE WITHIN 30 DAYS.**

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. Monday appointment cancellation must be received by the previous Friday. You will be charged a session fee of $30.00 for missed appointments. Repeat missed appointments can result in dismissal from the Practice.

LETTERS OF PROTECTION: I understand that I will not be seen unless my attorney has provided this office with a letter of protection to ensure that payment will be made for services rendered in the event the auto insurance does not pay or the policy coverage is terminated.

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.

Insurance Company Name_____ Claim #_____

Attorney Name _____

Attorney Phone / Fax _____

Please Print Name of patient or responsible party_____

Signature of patient or responsible party_____ Date_____