



Associates for
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PATIENT NAME: _____

Thank you for choosing Associates for Psychiatric Services, P.C.

In order to better serve you, please read this thoroughly and sign at the bottom. If you have questions, please advise.

It is our policy to identify the benefits that are available to you under the terms of your insurance plan. The benefits discussed with you represent information currently available to us.

However, this is not a guarantee of payment of benefits under your plan for the above-named patient. The claim is subject to all plan terms and provisions. This means that the benefits payable are determined according to the insured's eligibility, the limitations and exclusions (including pre-existing limitations) and conditions of the plan. Benefit determination will be made at the point the claim is processed.

However, we wish to stress the financial responsibility for services provided rests with you, the patient, or your family, regardless of any insurance coverage. The deductible or co-payment amount is always the responsibility of the patient. Your insurance company is a contract between you and the respective insurance company. We cannot guarantee payment of your claim. If your claim is not paid, the insurance company should explain to you why it was denied. We ultimately look to you for payment, not your insurance company. Again, if claims are denied (not covered by your insurance company), payment is expected from you.

It is also our policy that we be notified 24 hours in advance if you are unable to keep a scheduled appointment or if you need to reschedule an already existing appointment. Failure to give us proper notice may result in a \$50 charge for that missed or vacant appointment slot.

I have read the above disclaimer and have been given a copy.

Print Patient Name: _____

Signature: _____

If Not Patient, Relationship to Patient: _____

Date: _____