CONSENT FOR CARE AND TREATMENT

I, the undersigned, do herby agree and give my consent for Meridian Advance Psychiatry to furnish medical care and treatment to _______________________________ as considered necessary and proper in diagnosing or treating his/her physical and condition.

_________________________________ Patient and/or Guardian Signature

___________________________________ Patient and/or Guardian Print Name

__________________ Today's Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Meridian Advanced Psychiatry. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

_________________________________ Patient and/or Guardian Signature

___________________________________ Patient and/or Guardian Print Name

__________________ Today's Date

TELEPHONE CONSUMER PROTECTION ACT

I, the undersigned, do authorize Meridian Advanced Psychiatry and its designees to deliver messages containing account, marketing, or other non-health care messages to the phone number(s) on my account via an automatic telephone dialing system or an artificial or prerecorded voice. I understand that I am not required to agree to receive such automated calls and my agreement is not a condition to receiving items or services from Meridian Advanced Psychiatry. Meridian Advanced Psychiatry does not waive and expressly reserves the right to contact a patient using any method permitted by law.

_________________________________ Patient and/or Guardian Signature

___________________________________ Patient and/or Guardian Print Name

__________________ Today's Date

PATIENT FINANCIAL AGREEMENT & POLICY

Welcome to Meridian Advanced Psychiatry! And thank you for choosing us. In order to reduce confusion and misunderstanding related to financial responsibilities, we have adopted the following financial agreement. If you have any questions regarding this agreement, please discuss them with our Billing Office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care.

MAP will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require arrangements for payment of your estimated charges today. If your insurance carrier does not remit payment within 60-days, the balance will be due in full, from you. Any unpaid balance after the first 30 calendar days of service may accrue 1.5% interest each month thereafter. In the event your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes a usual and customary fee schedule, you will be responsible for the remaining difference. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment received to Meridian Advanced Psychiatry.
I understand that the cost of medication and other treatment(s) are not included in this Financial Agreement—only services provided by Meridian Advanced Psychiatry are applicable under this policy.

I understand and agree my account, if not paid, may result in my account being turned to an outside collections agency. If I fail to make any payment for which I am responsible to under the time limits herein, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Your health insurance policy is a contract between you and your insurance company. It is your responsibility to know the specifics of your insurance coverage and benefits, including in-network verification. If you have any questions regarding the cost of a specific service, please inquire prior to services being rendered.

We have made prior arrangements with some health care plans to accept an assignment of benefits. Please call your insurance company prior to your appointment to determine if our facility is a participant in your plan. We will submit a claim to those plans for which we have a contractual agreement and will require you to pay your authorized co-payment at the time of service. We will collect all co-payments and deductibles as soon as you arrive for your appointment. We accept checks, money orders, VISA, MasterCard, Discover, AMEX, or cash. It is your responsibility to be prepared to make your co-payment when you check in. If you are not able to make your co-payment, you may be asked to reschedule your appointment to a time when you are able to do so or be referred to our billing department for financial counseling.

If you have a health care plan we do not have a contractual agreement with, we will prepare the claim for you on an unassigned basis. In this instance, our charges for your care will be your responsibility and will be due once services are rendered and associated documentation/coding is completed. We must emphasize that as Providers, our relationship is with you, not with insurance companies, and insurance companies may calculate their re-imbursement rates to you in a manner that may not fully cover your charges. It is important that you understand your health insurance policy and the coverage it provides.

Please bring a current copy of your insurance card and current referral if required by your insurance at the time of your visit. If applicable, please bring a copy of your current Medicaid/Healthy Connections card or if your application is in process, documentation from Medicaid that this will be a covered service. Healthy Connections patients also will need to bring their Healthy Connections referral or make arrangements to have it sent or faxed to our office from your Primary Care Physician prior to your visit. If proof of insurance is not provided, you will be expected to make payment in full once services are rendered and associated documentation/coding is completed.

Please advise us of any change in address, phone number, or insurance

For the following items, please indicate that you understand by printing your initials:

________ In order to provide the best possible service and availability to all our patients, please call as soon as possible if you know you will need to reschedule your appointment.

________ Not all health plans are the same nor do they all cover the same services and supplies. In the event your health plan determines a service or supply to be "not covered," you will be responsible for the complete charge for that particular service. Payment is due upon receipt of a statement from our billing office. If you need to make arrangements for a payment plan, please contact our Billing Office (True Integrity Billing) 208-605-3662.

________ There will be a $25.00 charge for insufficient funds when checks are returned.

I have read and understand the financial policy of Meridian Advanced Psychiatry and agree to be bound by its terms. I also understand that such terms may be amended from time to time by Meridian Advanced Psychiatry. By signing below, I acknowledge that I fully understand and comprehend the full responsibility of fees and payments due for services rendered at Meridian Advanced Psychiatry.

_______________________________	_________________________________	_________________
Patient and/or Guardian Signature	Patient and/or Guardian Print Name	Today's Date

Version: 13 February 2024