Compass Clinical Associates P.L.L.C.
IMPORTANT FINANCIAL INFORMATION
Please Read Carefully

Authorization for Services

Our clinicians participate with various HMO's, PPO's and other managed-care organizations. Some of these plans require preauthorization before the first visit. I understand it is my responsibility to obtain this authorization. Mental health benefits may differ from medical benefits so it is essential that I have researched my mental health benefits prior to my visit. If I have not done this prior to my visit and/or treatment is not a payable benefit, I will be responsible for the full payment at the time of service. Further, if my insurance carrier determines that the services I receive are not medically necessary, I will be responsible for full payment of the bill.

Payment at the Time of Service

I understand this office's policies regarding payment for services. I will make payment in full at the time of each visit unless other arrangements have been made in advance. Insurance will be filed by the office at no charge and I will make any deductible, co-payments, or non-covered service payments at the time of service. If I must be billed there will be a $10.00 service fee.

Canceled or Missed Appointments

I understand that when scheduling an appointment, I am reserving professional time in advance. It is my responsibility to keep scheduled appointments. If unable to keep an appointment, I agree to provide a minimum of 24-hour notice during business hours. I acknowledge that a pattern of missed appointments constitutes grounds for unilateral termination of services. I will pay a minimum of $55.00 for all missed appointments and appointments canceled without 24-hour notice. I acknowledge that my insurance plan will not cover these fees.

Telephone Consultation

I will pay for all telephone consultations requested in lieu of a scheduled appointment or to discuss non-urgent medication or clinical concerns (minimum of $25). I understand I will not be charged for calls the clinician requested of me for updates. I acknowledge that my insurance plan will not cover these charges.

Prescription Refills

The expectation is that I will obtain prescriptions at the time of my appointment. I will pay for each prescription called into a pharmacy and/or those written in lieu of obtaining the prescriptions at the time of my appointment (minimum $15). I acknowledge that my insurance will not cover these charges.

Requests for Records

I agree to pay for any copies of records sent to other facilities, providers, or insurance companies regarding my care (minimum $35). I also agree to pay for any reports or letters requested by or sent to a third party.

Court-Related Work

If my clinician is called upon to appear in court, testify in court, or prepare reports for the court related to services received, I agree to pay for all such services.

Custody of Dependents

I understand that as the parent/guardian bringing my child for services, I am responsible for the payment of services provided to my child.

I have received a copy of this document and assign any insurance benefits to be payable to Compass Clinical Associates P.L.L.C.

Signature_____**Date**_____

(legal guardian if under 18 years)