Kim Butler, PMHNP & Bend Psychiatry
Financial Policy

We would like to keep you informed of our current financial policies. Please read the following policies carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Health Insurance:

1. It is your responsibility to keep us updated with your current primary and secondary insurance information. If the insurance information you the designated is incorrect, you will be responsible for payment of services and to submit the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regard to covered services, copayments, coinsurance, and deductible amounts. You are responsible of services not covered by your insurance plan.
3. Per your contract with your insurance company, you are responsible for any and all co-payments, coinsurance percentages, and deductible amounts.
4. Per our contract with your insurance company, we are required to collect any and all co-payments, coinsurance percentages, and deductible amounts. To not collect these amounts would be at the possible consequence of insurance fraud as defined by the Office of the Inspector General of the Department of Health and Human Services, and subject to civil and criminal liability.

Financial Responsibility:

1. Co-payments are due at time of service,. And prior balances must be paid prior to your next office visit.
2. While the filing of insurance claims is a courtesy we extend to our patients, all charges for services not covered by your insurance plan are your responsibility.
3. If your physician does not participate in your insurance plan, payment in full is expected at the time of your office visit.
4. If you do not have insurance, payment for an office visit is to be paid at the time of your office visit.
5. Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
6. Account balances over 90 days old will be turned over to an outside agency and will be subject to interest charges and the terms and conditions of that agency. Accounts turned over to collections may be subject to dismissal from the practice and termination of relationship between you and your physician.
7. we accept cash, checks, Visa, MasterCard, Discover, and American Express credit, and debit cards.

Appointments:

1. Please help us serve our patients better by keeping your scheduled appointments. If you are not able to keep an appointment, we require 24-hour notice for cancelling or rescheduling appointments. There is a charge of $100 (for late cancellation, late rescheduling, or missed appointments). There is a charge of $150 (for late cancellation, late rescheuduling or a missed Psychiatric Evaluation appointment).

2. If you are late for your appointment, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment and you may be charged the customary fee for a missed appointment.
3. Multiple missed appointments may result in dismissal from the practice and termination of relationship between you and your physician.
4. We strive to minimize any wait time. However, emergencies do occur and may take priority over a scheduled visit. We appreciate your understanding.

Returned Payment:

1. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

Please read and sign the other side (p.2) ---->>>>

Service Fees	Fee	Cash
Psychiatric Diagnostic Evaluation/Assessment (60-90 min) Simple/Complex	$425-$525	$350
Medication Management w/psychotherapy (30 min) Simple/Complex	$275-$350	$175-$225
Medication Management w/psychotherapy (45 min) Simple/Complex	$325-$400	$250-$375
Medication Management Only (15 min) Simple/Complex)	175-$325	$150
Psychotherapy Only (45-55 min)	$200	$180
Late Cancel or No Show (not covered by insurance)		$100
Late Cancel or No Show Initial Evaluation (not covered by insurance)		$150
Returned Check Fee		$25

I have read, understand, and agree to comply with the above listed policies. I have been provided opportunity to ask questions about anything that was not clear to me and I am satisfied with the answers I have received.

Patient Name: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Cardholder Name (as shown on card):
Card Number: 3-Digit Security Code:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I,_____, authorize Bend Psychiatry to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Patient Name: _____

_____ _____

Customer Signature Date