Clarity Mental Health
Bring your life back into focus

Jill Standley APRN, MSN, PMHNP-BC

FINANCIAL AGREEMENT: I agree to pay for services rendered according to this health care provider's rates and terms. I understand the services rendered may not be considered eligible for benefits (e.g., services may be determined to be not medically necessary, non-covered or investigational) by my health insurer. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services. I understand that I am financially responsible for all related charges not covered by my insurance. If insurance payment is not received after 45 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing and I may be required to pay interest on any unpaid past due balance. If this account is referred to an agency or attorney for collection, I agree to pay agency and attorney fees, whether or not a lawsuit is filed. Both collection agency fees and attorney fees will increase my balance.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to this health care provider and/ or agents of this health care provider relating to any/all insurance or health plan benefits.

RESPONSIBILITY FOR PERSONAL PROPERTY: I agree that this health care provider, or his/her agents are not responsible for my personal items. I hereby release the health care provider from all responsibility relative to the loss and/or damage to money and/ or valuables and/or property.

FINANCIAL CERTIFICATION: I certify the information given by me is correct and I have read and consent to the terms of financial agreement. I am the patient or I am authorized as the patient's agent or representative to execute the above and accept its terms on behalf of the patient, or I assume individually all financial responsibility by signing below.

CANCELLATION POLICY: I acknowledge I have been informed of the following: **all cancellations must be made 24 hours prior to your scheduled appointment.** Failure to cancel within 24 hours will result in a charge up to the full session fee for the missed appointment, no less than $50.00. This charge is NOT billable to insurance and is the patient's responsibility. **An appointment for Monday needs to be canceled before close of business on the Friday before, in order to avoid a missed appointment charge.** I also acknowledge that late arrivals, further described below, are subject to cancellation fees.

LATE ARRIVALS: I acknowledge an understanding that if I arrive to my scheduled appointment greater than **10 minutes** late for follow-up appointments and **15 minutes** late for initial appointments, my appointment may need to be re-scheduled if full services are unable to be performed in the alloted remaining time. If my appointment needs to be re-scheduled because of my late arrival, I understand I will be expected to cover the fees associated with that appointment in accordance with the cancellation policy listed above.

_____ _____

Patient Signature or Person Assuming Financial Responsibility **Date**

_____

Please print name