Linder Psychiatric Group, Inc.
[] 193 Blue Ravine Rd. Suite 170 Folsom, CA 95630 Ph: (916) 608-0714 Fax: (916) 608-0717
[] 970 Reserve Drive Suite 205, Roseville, CA 95678 Ph: (916) 780-1070 Fax (916)780-1199
[] 508 Gibson Drive Suite 150, Roseville, CA 95678 Ph: (916) 865-3670 Fax (916)780-0303
Hours of operation 7:30am-5:00pm Clinicians Pagers/Cell Phone Available 24 hrs
Website: www.echildpsychiatry.com

Confirmation of Benefits/Patient Rights & Responsibility Statement

We have verified the following information regarding your insurance policy benefits for psychiatric services. We verify insurance benefits as a courtesy to our patients and are at no time responsible if incorrect information is provided by the insurance company. Your insurance company authorizes us to evaluate you, but does not guarantee payment. If your insurance company has exclusions by diagnosis or for "non-covered" services, you will be fully responsible for the entire bill. You are responsible for informing the office of any change of address, phone, or insurance. We do no accept all insurances.

This office files insurance claims to your primary insurance company as a courtesy to you, one time, at no charge. We will re-bill or resubmit any claims upon request, one additional time, at no charge to you up to (30) days from the date of service. For any sub sequential claim re-submissions or claims that must be re-billed; there will be a $5.00 charge per claim/per submission. After (30) days from the date of service, **you will be responsible in full and will have to follow up with your insurance company** regarding unpaid claims unless otherwise specified by your health plan. We will gladly provide you with appropriate copies for you to submit to your insurance company so that you may be reimbursed. Accounts 45 days past due are subject to 18% APR interest rate.

Charges are subject to review by your insurance company and if denied, you are personally responsible for any amount that your insurance company does not pay. In the event that collection or litigation services are necessary, you will be liable for all expenses incurred, including an administrative charge of $35.00. Information would be released to a credit reporting agency and would be available to members of the public who may gain access to information in the possession of the credit reporting agency. I agree to participate in a binding arbitration process in lieu of the legal process in the unlikely event that I find that necessary.

To keep your account up to date, we ask that you make your co-payment before each visit or on the day of your visit. You may pay by cash, check, Visa, or MasterCard. Furthermore, you may be asked to place a credit card on file if you are a fee-for-service client, have an outstanding balance on your account, or if your insurance company is requiring you to satisfy a deductible. This information would be kept private and confidential and in a secure location. **In addition, if you fail to cancel your appointment 72- business hours in advance, or you are too late to be seen, you will be responsible for full payment for that appointment.**

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I. Permission to Treat

I hereby volunteer for admission to outpatient mental health services, and consent to the care and treatment ordered by my mental health practitioner assigned or selected by me. If I am the guardian of a minor in treatment, I consent to their care and treatment. I have the right to refuse to participate in treatment. There are risks and benefits to treating and not treating mental health conditions that your assessing clinician will discuss with you.

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Client or Guardian Initial

II. Authorization for Release of Information

Our agency may disclose information to Protect Health Information (PHI) for any health care operation and/or any party obligated for payment of services provided to me. Linder Psychiatric Group, Inc. may disclose information to any party obligated for payment of services provided to me. This information includes, but is not limited to, dates of service and diagnosis. This release may be to medical service companies, insurance companies, collection agencies, worker compensation carriers, welfare funds, or other mental health providers working with Linder Psychiatric Group, Inc.

I understand that as part of my treatment, my diagnosis and treatment may be shared with my Primary Care/Referring Physician to apprise him/her of the status of my care. Except for the above, whatever my therapist/psychiatrist and I discuss is confidential. The therapist/psychiatrist will not release any information about my treatment unless permitted by law or upon my written consent. I understand that my therapist/psychiatrist has the legal responsibility to inform the proper persons if I intend to harm myself or others. I also understand that the therapist/psychiatrist is obligated by law to report to authorities any incidents of child, or elder abuse and injuries resulting from the use of a deadly weapon or as a result of assault or abusive conduct (in the past or present). In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers, documents, and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

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III. Missed Appointments (No Show/Cancellation Policy)

I will pay for all missed (including too late to be seen) appointments and those canceled with less that 72- business hours (3- business days) notice. I understand that the 72- business hours exclude holidays and weekends. I understand insurance will not be billed for missed or canceled appointments (unless otherwise stated in rules of the health plan.) One "no show" appointment may result in not being rescheduled for future appointments. I may not cancel/change more than two appointments in a row, even with 72- business hours notice. Please understand that timeliness is imperative so that the therapist/psychiatrist can spend the whole time allotted with you.

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Client or Guardian Initial

IV. Additional Fees and/or Charges

Private-pay (Fee for Service) payments and co-pays are due before or on the day of your appointment, otherwise a late fee of $20.00 will be assessed. If we must bill you for these types of payments, a $7.50 billing fee will be assessed for each statement. There is a $35.00 return check fee. Additional claim re-submissions or claims that must be re-billed will be billed to the patient for a $5.00 fee per claim per submission. Disability paperwork, letters, and other paperwork will be billed to the patient at an hourly rate and fees must be paid by the patient in advance. All phone pages will be billed to the patient at $35.00 per (5) minutes of returned call time for Linder Psychiatric Group, Inc. Office phone calls lasting longer than (2) minutes will be billed to the patient at $45.00 per (10) minutes; or at the discretion of the therapist/psychiatrist may be billed as an appointment.

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Client or Guardian Initial

Confirmation of benefits and patient responsibility policies are subject to change by Linder Psychiatric Group, Inc. without further notice.

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Patient/Authorized Person's Signature Date