



Sterling Behavioral Health Services, LTD

Patient Name: _____ Date: _____

Financial Policies Agreement

Revised: 12/20/2006

This agreement supersedes all previous related agreements.

Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements. We will gladly submit fees for your covered medical services to your insurance company, if your provider is considered in-network. However, we expect payment of all services rendered within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. X_____ (Please initial)

I understand that SBHS will file and attempt to collect from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges.

X_____ (Please initial)

If your insurance coverage or your insurance carrier changes and you do not notify SBHS within 30 days of that change, SBHS reserves the right to NOT issue a refund. I agree to waive any insurance company policy rights that require refund of the aforementioned monies. X_____ (Please initial)

Payment for Services

Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard and Visa. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

X_____ (Please initial)

Failure to pay your co-pay at the time of service will result in a charge of \$20.00 to help cover the additional administrative costs. You will be asked to sign a promissory note for the co-pay amount plus the service fee.

X_____ (Please initial)

Returned checks will result in a \$50.00 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt. SBHS has a "One Bad Check" Policy. If your account has one returned check then you will not be allowed to write checks for future services.

SBHS is a partner in the Loudoun County Commonwealth Attorney's check enforcement program and as such we are required to note a current / valid ID on each check. X_____ (Please initial)

General

Sterling Behavioral Health Services, LTD
20905 Professional Plaza, Suite 220
Ashburn, Virginia 20147
Voice: (703) 858-9841 Fax: (703) 858-9446
www.pceva.com



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We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered. X_____ (Please initial)

1. I accept financial responsibility for all clinical and administrative services provided by Sterling Behavioral Health Services, LLC.
2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.
3. I authorize payment to Sterling Behavioral Health Services, LLC for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.
4. In many cases, there is a need for us to exchange information with other parties, such as other treating physicians. If you do NOT wish to give us permission or have any doubts about granting this permission at this point to exchange information with other physicians, please cross out this paragraph. If you cross out this paragraph, we will ask you to sign separate release of information forms when and where appropriate.
5. Ancillary services, including exchange of information, as in #4 are billed as follows: Psychiatrists bill at an hourly rate of \$300.00 per hour. Legal services are billed at a rate of \$350.00 per hour. Psychologists bill at a rate of \$175.00 per hour and \$43.75 per 15 minutes for ancillary services. Legal services are billed at a rate of \$300 per hour. Therapists or Master's level licensed clinicians will bill at a rate of \$150.00 per hour and \$37.50 per 15 minutes for ancillary services. Legal services are billed at a rate of \$250 per hour.
6. If my account goes to a third party for collections, I am responsible for all fees incurred.
7. I understand that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. If you are unsure of your balance you may call SBHS.

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Patients Name: _____ Signature: _____

Parent / Guardian's Name: _____ Signature: _____

Witness: _____ Date: _____