**FINANCIAL POLICY**

Thank you for choosing us as your Health Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment process. The following is a statement of our financial policy, which we require you to read and sign, prior to any treatment.

Before your scheduled appointment with the doctor, patients must complete the Client Information Forms, and submit copies of insurance card(s) and/or verification of insurance.

---

REGARDING INSURANCE*:* Dr. Macellari accepts assignment on Medicare, Community Health Alliance, Meritan, Aetna, Anthem BC/BS, United Healthcare and New Avenues/MBHN.

For any other insurance company that Dr. Macellari is NOT contracted with, (out-of-network) a $50 co-payment for office visits is required until we know what your responsibility for each visit will be. At that time your co-pay and co-insurance payments will be expected at each visit.

Any testing may include an additional fee and co-insurance is expected at the time of service.

MMPI-2 - $705.00
Mental Status Exam - $705.00
Neuropsychological Test Battery - $3000.00

Our office accepts cash, checks, Visa, MasterCard and Discover.

We will bill your insurance company.

Your insurance policy is a contract between **YOU** and **YOUR** insurance company. We are not a party to that contract.

Please be aware that some, or perhaps all, of the services provided may be non-covered services or may not be considered reasonable and necessary under your medical insurance.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of what is usual and customary.

MINOR PATIENTS: The legal guardian(s) of a minor is responsible for the required payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by cash or check is made at time of service. _____**Initials**

EMERGENCY TELEPHONE CONSULTATION: Phone calls returned by Dr. Macellari for consultation, during regular office hours, will be billed at the regular office rate of $235.00 per hour (i.e. 15 minute call will be billed at $58.75). In the event that your insurance company does not reimburse for such telephone consultation, you are liable for these charges. Your initials indicate that you understand and agree to this policy.
_____**Initials**

MISSED APPOINTMENTS AND NO SHOWS: A specific time has been reserved exclusively for you when a therapy appointment is made. Therefore, notice is required 24 hours in advance of the scheduled appointment should you find you would be unable to keep your appointment. Appointments canceled with less than 24-hour notice will result in an assessment of half the fee charged for a full session. Should you fail to keep a scheduled appointment without any advance notice (i.e. no show); a fee will be assessed at the full session rate. It should be understood that insurance policies **will not cover** costs incurred due to missed appointments. After 3 cancellations with less than 24 hours advance notice or 2 cancellations with NO advance notice (i.e. "no show"), no future appointments will be scheduled. Please help us serve you better by

keeping scheduled appointments. Your initials indicate that you understand this possibility and agree to this policy. _____ **Initials**

CONFIDENTIALITY DISCLAIMER: Understand that you are financially responsible for any remaining balance on your account once reasonable efforts to collect from your insurance company have been made. However, failure to respond in a reasonable manner to any accumulated debt on your account may result in involving our attorney. Should this occur we follow all HIPAA requirements to protect your confidentiality. Your name, address, account balance, and other identifying information necessary to the collection procedures may be legally released to collect payment of debt. Your initials indicate that you understand this possibility and agree to this policy. _____**Initials**

DEBT COLLECTION COSTS: I agree that in the event that my account is turned over for legal action, I will be responsible for all costs including attorney fees, court costs and interest incurred to secure the collection of my debt. Your initials indicate that you understand this possibility and agree to this policy.
_____**Initials**

PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

By signing this form I acknowledge that I have read the entire Financial Policy and I understand and agree to it.

_____ _____
Signature of patient/Responsible Party Date

*Effective December 13, 2012*