Psychiatry of SA
210-742-6551
www.psychofsa.com

Patient Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our "Financial Policy" which we require that you read and sign prior to our rendering any service or treatment is rendered.

Payment in Full is Due At The Time Of Service Unless Prior Arrangements Are Made.
We Accept Cash, Visa, Master Card. We DO NOT accept Checks.

Insurance Participation

We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and Deductibles be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of your insurance cards. Blood lab fee will be charged to your insurance company but in the event of non coverage test, you will be responsible to pay for tests. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements.

Patient consents to Email, text and voice reminders and messaging. Patient gives consent to retrieve prescription history when request is triggered.

Adult Patients

Adult patients are responsible to adhere to the above policy which may require full payment at time of service.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. **Unless cancelled, at least 24 hours in advance, our policy is to charge $50.00 fee for appointments not cancelled 24 hours in advance.**

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the "Financial Policy" and agree to abide with the requirements.

Name: _____ Date: _____

Signature: _____

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CONSENT FOR TREATMENT

General Consent to Treat

I voluntarily consent to treatment and/or related services by Psychiatry of SA which may be advised and recommended by the attending physician. I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for Psychiatry of SA to render such emergency treatment and/or transfer myself or my child to a hospital for treatment. In event of suicidal or homicidal thoughts, I agree to immediately call 911, reach out to suicidal hotline or go to the nearest emergency room for treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this organization.

I understand that at Psychiatry of SA, patient evaluation and treatment is provided by Mid-level provider (Nurse practitioner or Physician Assistant) under supervision of a physician. My information will be shared with the physician for auditing and treatment planning. I understand that I have a right to refuse care from Mid-level provider at this office. However, I will be responsible for immediately finding another psychiatry practice on my own. This office will hold no responsibility in continuing care during the interim period. I understand that I may not be able to meet with the supervising physician.

I am aware that I may stop my treatment with Psychiatry of SA at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I understand that medication refill request will be addressed only during working business hours and may take as long as 72 hours to be completed. Medical record request, FMLA or any other paperwork may take as long as 4 weeks to be completed and I will be responsible for office charges.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Psychiatry of SA may stop treatment.

I acknowledge that I have received a copy of Notice of Privacy Practices which summarizes the ways my health information may be used and disclosed by Psychiatry of SA and states my rights

Name: _____ Date: _____

Signature: _____

with respect to my Protected Health Information (PHI). I understand that Psychiatry of SA has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Psychiatry of SA changes this Notice, a revised Notice will be posted in the office waiting area and that I may obtain a current Notice of Privacy Practices at any time from the front desk.

Dual Relationships & Social Media

Dual relationships can impair the therapeutic process, your therapist's objectivity, clinical judgment, or therapeutic effectiveness that could be exploitative in nature. I will never acknowledge working therapeutically with anyone without his/her written permission. In some instances, even with permission, I will preserve the integrity of our working relationship. For this reason, my social and social media policy is the same distance counseling clients as it is for in-office clients.

Records

The psychiatrist will maintain records of online counseling services. These records can include reference notes, copies of transcripts of chat and internet communications, and session summaries. These records are confidential and will be maintained as required by applicable legal and ethical standards according to the American Counseling Association and the Texas Administrative Code. The client will be asked in advance for permission before recording any audio or video session. When records are requested, the ultimate decision to release them is up to the supervising Psychiatrist.

Name: _____ Date: _____

Signature: _____