NEUMIND CLINIC

RM Psychiatry LLC

PATIENT INFORMATION AND AGREEMENT

Patient Name: Last _____ First _____ Middle Initial _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____ Email _____

In accordance with HIPAA, please answer the following questions:

May we leave messages on your voicemail or answering machine? € Yes € No

May we leave messages with any other person and/or do you authorize any other person to call regarding your medical information? € Yes € No

If yes, with whom? _____ Name _____ Relationship _____ Phone

If yes, with whom? _____ Name _____ Relationship _____ Phone

May we call you at work? € Yes € No

Emergency Contact: _____ Name _____ Relationship _____ Phone

Preferred Pharmacy: _____ Name _____ Town and street of Pharmacy

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Please initial each section.

_____ (Initial) I understand there is $50.00 “No Show” fee if I do not provide a minimum of 24 hours’ notice of my intent to not appear at a scheduled appointment.

_____ (Initial) I hereby authorize RM Psychiatry, LLC to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment of medical services. I hereby authorize payment of all medical/surgical insurance benefits to be directly to RM Psychiatry, LLC. **I understand I will be fully responsible for payment of any and all charges not covered by medical insurance, such as deductibles, copayments, and coinsurances, and for services I have signed a prior agreement to be responsible for if not covered by my insurance.**

_____ (Initial) Payment for services may be made by credit card, approved check, or cash. **Returned checks will be issued with a $25.00 return fee.**

_____ (Initial) Unpaid balances after 60 days will be subject to a $25.00 per month late fee. Accounts 4 months and older may require Collection Agency Action if an agreement between RM Psychiatry, LLC and myself (guarantor) has not been formally arranged. All collections fees will be my (patient) responsibility. In the event your account is sent to collections, the collection fee of 35% will be added to your account.

_____ (Initial) Insurance policies determine medical coverage. There are many different plans, independent of each other, within the same insurance company. **It is my (patient) responsibility to understand my medical coverage including but not limited to: (1) deductibles, (2) coinsurance and copayments, (3) services that require a referral. Any services, or referrals recommended by our providers are made strictly for medical purposes.**

PRIVACY POLICY

The HIPAA notice has been made available to me by RM Psychiatry, LLC

My signature is confirmation that I understand, and initial each section listed above.

_____ _____

Signature Date

Patients will have 60 days to review and remit payment on outstanding balances. After 60 days, a $25.00 late charge will be applied. Any dispute of balance must be made no later than 60 days from the date of service, or 60 days from the date your insurance makes final adjudication of your claim. After 90 days, unpaid balances will automatically be charged to your credit card account.

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