Medication Management Financial Policies and Procedures

Please initial each section to acknowledge understanding of the financial policies and procedures of Murray, Wilson & Rose Counseling and Behavioral Services, LLC (MWR). Please note, if not initialed, the MWR clinician and/or office will review with you verbally. *If you choose not to acknowledge understanding, this does not exclude you from financial responsibility.*

_____ FEES & PAYMENT:

MWR's fees for psychiatric evaluation and medication management begin at $100, and may be billed in excess of $325. Your session fee or copayment will be collected from you at time of service. If we decide on a different time frame, fees will be prorated accordingly. If you use your insurance, MWR will accept their rate of payment, collect any copayment at time of session, and bill the insurer. You are responsible for knowing your benefits and for payment of any fee or part of a fee that the insurer does not pay. MWR reserves the right to assess a financial charge on past due bills, or in extremely delinquent cases, turn them over to collections. If you require paperwork such as FMLA, ADA, disability, etc. to be filled out as part of your treatment, there is a fee of $35 per occurrence for this service that is billed to you directly, not through insurance. This will be due prior to paperwork being sent out.

_____ CANCELLATION POLICY

MWR clinicians make every effort to accommodate as many patients as possible during the times available during the week. For that reason, it is necessary to have a cancellation policy that is fair and reasonable for all concerned. When you must cancel, please provide MWR and/or your clinician notice by telephone or email at your earliest convenience. **You will be billed a $50 late cancellation fee for *same day cancellations* (this applies to any appointment that is cancelled on the day you are scheduled for an appointment) or *no-shows*.** If you have three no-show occurrences and do not provide adequate notice of cancellations, MWR reserves the right to terminate counseling services and provide you with referral to other medication management services.

_____ Patient is responsible for knowing insurance benefits and coverage. MWR Counseling submits claims to insurance carriers as a courtesy and cannot guarantee benefit information that they have been given.

_____ Patient is responsible for payment of copay, coinsurance, or deductible amount at time of service. If copay or coinsurance amount is unclear at time of service, patient may be subject to a visit fee of $30. If insurance pays fee in full, MWR will refund visit fee to the patient.

_____ If the patient is a minor, the responsible guardian/custodian must make payment arrangements with **Cindy Scott, MWR Office Manager, 319.250.1259,** to determine payments made at time of service.

_____ If there is a balance on the account, paper statements will be mailed the first week of each month. Remaining balance is due upon receipt of the statement and no later than the 28th of the month.

_____ MWR reserves the right to suspend/terminate treatment if patient balances reach in excess of $300 and appropriate financial arrangements have not been made. MWR will provide referral information to local agencies or providers that offer financial assistance in the form of sliding scale fees.

_____ Checks returned for insufficient funds will result in a $35 charge to the patient account.

_____ If materials are provided to patients for use and are unreturned, MWR reserves the right to charge patients for these materials.

_____ In the event there is overpayment on the account, reimbursements will be sent quarterly.

_____ MWR reserves the right to send patient accounts to collections if payments have not been made in 60 days.

I acknowledge that I have received Murray, Wilson & Rose Counseling and Behavioral Services fees, cancellation policies, billing/payment policies and procedures. I acknowledge that I have read the above information and clarified any questions or concerns. I understand that I have a right to a copy of this information.

PATIENT NAME: _____ SIGNATURE: _____

Witness/CLINICIAN: _____ Date: _____

I would like to receive a copy of this disclosure statement: ☐ Yes ☐ No