Riverpoint Psychiatric Associates
Consent for Treatment, Statement of Fees & Method of Payment Form

Name of Patient: _____ Date: _____

Name of Responsible Party: _____ SSN: _____

This form is utilized to establish a clear understanding regarding the details of your treatment as well as your financial account with our Practice. Please read it entirely and ask any questions you may have. **YOUR SIGNATURE IS AN ACKNOWLEDGEMENT OF YOUR UNDERSTANDING & AGREEMENT WITH THE PROVISIONS.**

I, _____ hereby authorize Riverpoint Psychiatric Associates (RPA) and/or its designees to provide medical treatment, counseling/psychotherapy, release information pertaining to treatment for insurance purposes, & to receive direct insurance payments for professional treatment otherwise payable to me for services rendered. **I understand that I am financially responsible for payment for all services at the time they are rendered unless other arrangements have been made in writing.**

I agree that RPA may call, or send a text message to, phone numbers provided by me to confirm appointments or leave reminder messages regarding appointments. ___
I agree that RPA may send me emails to the email address provided by me to confirm appointments, leave reminder emails about appointments & to send statements regarding charges & payment for treatment. ___
I also consent for Riverpoint Psychiatric Associates to access my medical & medication history from other medical providers & the Prescription Monitoring Program database.

It is my responsibility to understand my insurance coverage & benefits including precertification, referrals & authorization requirements. (We will assist you to ensure that all plan requirements are met. However, if there is a lapse in your coverage you, the patient, will be responsible for all outstanding balances. **This includes Medicaid patients).**

I agree to be responsible for payment in full of all charges for professional services which have been rendered to the above-mentioned Patient by Riverpoint Psychiatric Associates. I also understand & agree to the following provisions regarding the fee & method of payment:

If desired, Riverpoint Psychiatric Associates shall file insurance claims on behalf of the Patient for services rendered. Insurance payment shall be made directly to the Practice. Should payment be made to the Patient or Responsible Party by the insurance carrier, the Responsible Party agrees to promptly forward payment to the Practice.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Riverpoint Psychiatric Associates for any service furnished me by any provider in that group. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

The Patient or Responsible Party will supply to the Practice any insurance forms that may be necessary to expedite the filing process on a monthly basis.

The Patient or Responsible Party shall pay the estimated "co-insurance payment" **AT THE TIME OF EACH VISIT**. This is the amount which is ESTIMATED as not being covered by the Patient's insurance.

The Patient or Responsible Party shall pay any outstanding balance which is not covered by the insurance (e.g., deductible, co-payments, denied claims). The Patient or Responsible Party may receive a statement whenever there is an outstanding balance. **The Patient or Responsible Party- not the insurance company- is ultimately responsible for the payment for the services rendered (this includes Medicaid patients).**

It is understood that the usual and customary collection procedures may be initiated should the account become delinquent. This may include the referral of the account to a collection agency or attorney. The Patient and the Responsible Party authorize Riverpoint Psychiatric Associates to inquire into open or paid credit & the Responsible Party agrees to be responsible for all costs & expenses of collection, including but not limited to attorney's fees and/or collection agency fees of 33 1/3 % of the balance due.

By signing below, each of the Patient & the Responsible Party makes the following statement: I UNDERSTAND THAT IF I DO NOT PAY RIVERPOINT PSYCHIATRIC ASSOCIATES FOR SERVICES RENDERED, THAT RIVERPOINT PSYCHIATRIC ASSOCIATES MAY TURN MY ACCOUNT OVER TO AN ATTORNEY OR A COLLECTION AGENCY FOR COLLECTION. I ALSO UNDERSTAND THAT INFORMATION REGARDING MY DELINQUENT ACCOUNT MAY BE REPORTED TO A CREDIT REPORTING AGENCY. I ALSO UNDERSTAND THAT THE TURNING OVER OF MY DELINQUENT ACCOUNT TO AN ATTORNEY OR COLLECTION AGENCY FOR COLLECTION, & ANY REPORTS OR INQUIRIES TO A CREDIT REPORTING AGENCY, MAY DISCLOSE THAT THE PATIENT IS A PATIENT OF RIVERPOINT PSYCHIATRIC ASSOCIATES & I HEREBY CONSENT TO ANY SUCH DISCLOSURE.

I have been provided with a copy of this agreement.

It is understood & agreed that a charge will be placed on the account if an appointment is missed or canceled without 24-hour notice.

Additional details or considerations regarding the method of payment may be outlined below.

Patient's signature	Date	Responsible Party	Date