RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

FINANCIAL POLICY AND PATIENT RESPONSIBILITY EFFECTIVE 9/1/2016

We are committed to providing our patients with the highest quality of clinical care. We thank you for taking the time to read and understand our new policies. *Please initial at the end of each section.*

It is the "Patient's" Responsibility:

To know their insurance policy. Patients should be aware of their benefits coverage, including which clinicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information, such as deductibles, coinsurance, and copays. If you are not familiar with your plan coverage, we recommend you contact your insurance carrier directly. If a provider is considered out of your insurance network, the patient will be required to pay for mental health services based on the out-of-pocket rate. The office will provide an invoice and the patient may independently submit this invoice to their insurance company for reimbursement. I understand that the office will not do third party billing on my behalf when my provider is considered out of network with my insurance. _____ (Initial)

To obtain a referral from their Primary Care Physician (PCP) prior to receiving services. Any non-covered services, including, but not limited to psychological testing, assessment intake and feedback sessions, are the financial responsibility of the patient. Patients whose insurances require a referral must have the referring provider/insurance company provide our office with an electronic or official paper referral prior to your scheduled appointment. Scheduled patients who do not obtain a required referral prior to their appointment will not be seen for an appointment. _____ (Initial)

To pay their patient responsibility amounts at the time of service. Please help us continue to keep patient care our FIRST priority by promptly paying your patient responsibility amounts (*co-pays, deductibles, cost shares, coinsurance amounts, etc.*) at the time of service. **Failure to pay (co-pays, deductibles, cost shares, coinsurance amounts, etc.) at the time of service will result in you not being able to see your provider (psychiatrist, psychologist, therapist, or nurse practitioner)**. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays (*and other patient responsibility amounts*) can be considered fraud and we can be held in violation of our insurance contracts. _____ (Initial)

To pay for services in a timely manner. If your patient responsibility balance becomes greater than $250.00 at any time, The Office of Ramesh B. Eluri, MD, PC (RBE) requires payment agreements be made and followed in order to continue treatment. If at any time it is determined that good faith payments are not being made on an account, reserves the right to deny services till accounts are paid in full. Not fulfilling financial obligations to RBE is also grounds for discharge from the practice. _____ (Initial)

To pay any Medicare deductibles and co-insurance amounts not covered by their supplemental insurance at the time of service. I understand that Medicare typically provides 80% coverage of services. I understand that RBE is not contracted with Medical Assistance (MA) providers. I understand that this practice cannot bill any MA providers as a secondary insurance to collect the 20% balance. If I have MA as secondary insurance, I acknowledge I will be responsible for paying $20.00 at the time of each mental health visit to avoid accruing a large balance. _____ (Initial)

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It is the "Provider's" Responsibility:

To provide quality medical or behavioral health care that is consistent with best practices in psychiatry and psychology. _____ (Initial)

To file insurance claims. RBE will file a claim with primary, and, as a courtesy to our patients, secondary (excluding Medical Assistance) carriers only. We will not file claims for third, fourth or fifth insurances. A 30-day period will be extended for **pending** insurance payments, after which time the patient will be held responsible for the balance. _____ (Initial)

To provide accurate balance information. RBE attempts to collect any outstanding balance using monthly statements **AND** by asking for payment upon check-in. Payment on your account is due immediately upon receipt of statement. If you are experiencing financial difficulty, please contact our Office Manager. Our office will make every reasonable attempt to collect on your account prior to taking outside collection agency action. If your account is send to collections, your **FULL AMOUNT DUE** will need to be paid **IN FULL** before you will be able to reschedule with anyone within our practice. I understand that if I am delinquent in my payments applicable demographic information, as well as balances owed, will need to be disclosed in the interest of collection. _____ (Initial)

Additional Practice Related Fees:

Missed Appointments and "No Show" Fee Matrix: Varying fees will be charged for any and all missed appointments (**failure to provide cancellation notice of more than a full 24 hours will be considered a no show or missed appointment**). The fee charged is subject to change. Please see chart below:

Days	Time	Charge
Monday – Friday	Between 9:00AM – 5:00PM	$40
Monday – Friday	After 5:00PM	$60
Saturday	Any time	$75

Please note, if a reoccurring appointment is cancelled two times, future appointments will be cancelled. It is up to the sole discretion of your provider to determine if future appointments will be rescheduled. _____ (Initial)

I understand that if a personal check is returned for insufficient funds, I will be required to pay a $50 fee for bank charges and re-invoicing; if this occurs more than once, no personal checks will be accepted for future visits. _____ (Initial)

Requests to complete LIFE, DISABILITY, FMLA, and other forms:
$25 per each ½ hour (*administrative fee*). _____ (Initial)

Co-Pays and Co-Insurance:
These are due at the time of service. Services will not be provided unless payment is received. A $10 administrative fee will be added to any account when this is not paid at the time of service. _____ (Initial)

(All fees listed above are subject to change.)

FINANCIAL POLICY ACKNOWLEDGEMENT

(Mandatory for All Patients)

By signing my name below, I acknowledge that I have read and understand the updated 2016 Financial Policy for the Office of Ramesh B. Eluri, MD, PC. I understand that, regardless, of my insurance claim status or absence of insurance coverage, **I am ultimately responsible for the balance on my account for any services rendered**. I understand that payments can be made by cash, check, MasterCard, Discover, or Visa. I understand that if my balance remains unpaid that my account will be referred to a collection agency or attorney. In such cases, only my demographic information and billable appointment dates will be made available to the collection agency and/or attorney. I agree that if there is a past due balance on my account that I will be responsible for all costs of collection on my account including attorney's fees and any interest on balances due.

PATIENT SIGNATURE: _____ **DATE:** _____

STATEMENT OF VOLUNTARY CONSENT, GENERAL RELEASE AND WAIVER OF LIABILITY

In consideration of my voluntary participation in mental health treatment at The Office of Ramesh B. Eluri, MD, PC I, _____ assume all responsibility for any dangers, risks or mental or emotional injuries as a result of my outstanding bills being sent to a collection agency. I further hereby hold harmless and release and forever discharge The Office of Ramesh B. Eluri, MD, PC, Owners, Management, my Provider, and their successors, from any and all claims and demands whatsoever, which the undersigned, and their heirs, representatives, executors, administrators and personal representatives thereof, or any person acting on behalf of their respective agents, have or may have against any or all of the aforementioned persons or their successors, by reason of accident, illness, injury, property loss or damage or any other consequences arising or resulting, directly or indirectly, from the collection efforts and practices associated with the collection agency retained by the The Office of Ramesh B. Eluri, MD, PC. I hereby declare and represent that in making, executing, and tendering this Statement of Voluntary Consent, General Release and Waiver of Liability, I fully understand and acknowledge by my signature, that I am relying wholly upon my own judgment, belief and knowledge of the circumstances involved in my participation in mental health treatment, and I have read this Statement, understood its contents, and execute it of my own free will and choice.

PATIENT SIGNATURE: _____ **DATE:** _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

(*Mandatory for All Patients*)

By signing my name below, I authorize the release of medical information necessary for filing health insurance claims for me by the Office of Ramesh B. Eluri, MD, PC. I also authorize my insurance carriers to make payments directly to these companies.

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT NAME (PRINT) _____