NAPERVILLE
CLINICAL ASSOCIATES

WELCOME TO NAPERVILLE CLINICAL ASSOCIATES (NCA)

Thank you for choosing Naperville Clinical Associates for your mental health needs. Please read the following polices and sign at the end of the form to indicate your understanding.

APPOINTMENTS: If you are unable to keep your appointment or are going to be late, please call our office as soon as possible. This courtesy allows us to make the time available to other patients. The clinician's usual fee can be applied to your account for missed appointments or cancellations after 9 A.M. on the previous business day. This means that Monday appointments should be canceled before 9 A.M. on Friday, Tuesday appointments before 9 A.M. on Monday and so forth.

Time spent with you on the telephone by your physician/therapist other than for appointments or medication questions may be charged at a rate of $25 for five minutes and $50 for ten minutes and over.

CONFIDENTIALITY: Mental health law dictates that we can neither confirm nor deny that a patient is being seen in our practice without **written** authorization from the patient. This includes **all** family members. Please be advised that questions regarding billing matters will be discussed with **only** the patient or guardian. In keeping with generally accepted procedures in the mental health field, patients are not normally given access to their chart or chart notes. In the event of a request for the transfer of records to a new therapist or doctor, the records will be forwarded directly to that person upon completion of a release of information form by the patient, and a fee may be charged in compliance with the Illinois statute for record copying fees.

PRESCRIPTIONS: Please allow **48 hours notice for all medication refills**. Requests made after noon on Friday or on Saturday and Sunday will not be filled until late Monday afternoon. We only accept phone requests for certain medications, as your doctor will explain. For all other medications, please ask your pharmacy to send your refill request to your doctor electronically.
WE DO NOT ACCEPT FAX REQUESTS FROM PHARMACIES.

NCA FINANCIAL FEES POLICIES: Please understand that payment of your bill is part of your treatment and care. The following is a statement of Financial Policy, which we require all of our patients to read, understand, and sign prior to treatment and care.

WHEN PAYMENT IS DUE: *Payment is due at the time services are rendered in the office* unless prior arrangements have been made with the business office. A $40 fee will be charged for any check returned by our bank as non-collectable. In order for our clinic to offer you our highest quality of services, all balances over 60-days and/or any account that reaches a balance of $300 must be paid in full before you are able to schedule future appointments. If charges are unpaid after 90 days, your account may be turned over to a collection agency with any information they may require for collection of said debt. Should your delinquent account be turned over to a collection agency or attorney, please be advised that you will be responsible for court costs, attorney fees and collection fees.

METHODS OF PAYMENT: We accept cash, check, Discover, MasterCard and Visa.

INSURANCE: We accept assignment of insurance benefits if we have a provider contract with your insurance company. This will be verified prior to your first appointment. If we accept your insurance, you are responsible for co-pays, contract deductibles and any amount not paid by your insurance with the exception of provider contracted reductions.

Medicare patients are expected to make co-payments at the time of service unless you have a secondary insurance. Medicare patients who are seeing Dr. Morrison must sign a contract as required by Medicare, prior to your first visit.

The patient is solely responsible for obtaining the necessary authorization from their insurance affiliate **before** their first appointment and agrees to pay said appointment fee in full if it is later determined authorization was needed. Please cooperate with our staff in providing this information.

In the event an authorization is issued but the insurance company refuses to pay for the services, the balance due will be your responsibility.

Please remember, insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for the timely payment of your account.

ABOUT OUR STAFF: Our staff has been trained to understand all the insurance for which we are contracted with, but, they do not have all the answers. It is the patients' responsibility to contact your employer for a copy of your Benefits or call your insurance company. They can offer the most detailed information about your coverage. You may also contact your company's Human Resource Department.

In order for us to successfully bill your insurance company for you, we need complete, up-to-date information at the time of registration as well as anytime in the future your information changes..

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns

I have read, understand and agree to the above clinical and financial policies. I hereby agree to assign to my doctor/therapist the medical benefits to which I and/or my dependent are entitled to under any health insurance plan**. I authorize my doctor/therapist to furnish to my insurance company all information, including treatment records, which they may request concerning treatment for myself and/or my dependent. This includes records that may be required to obtain prior authorization of medication coverage. Naperville Clinical Associates is not responsible for these records once they leave our office.**

I give my consent to my doctor/therapist to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I am participating in my treatment voluntarily and I understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

PLEASE SIGN AT BOTH X'S

(X) Patient's Signature: _____ Date: _____

Print Name: _____

Guardian's Signature: _____ Date: _____
(Necessary for patients under the age of 18)

Print Name: _____

(X) Signature of Responsible Party: _____
(Person responsible for payment)

Print Name: _____

Address (if different from patient): _____

Phone (if different from patient) Cell: _____ Home: _____ Work: _____