Southern Psychiatry

Financial Policy

To avoid any misunderstanding, we are providing you a copy of our office's financial policy.

Please be advised that your payment is expected at the time services are rendered unless PRIOR arrangements have been made. For your convenience, you may pay by cash, Visa, MasterCard, American Express, or Discover. If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician.

We encourage you to contact your insurance company to verify your benefits and the possibility for reimbursement. The **PATIENT** will be responsible for filing all claims with their insurance company. This office will provide your insurance company with any necessary information to assist in your reimbursement. Please be aware that it is possible that you will not be reimbursed by your insurance company (Medicare and Cigna in past experience).

In order to give you, and all our patients, the best possible care, we request that you review our policy regarding **missed appointments**. Please see below.

- A **missed appointment** is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24-hour notice before we will reschedule your appointment. This will enable us to offer your cancelled time to other patients.

- If you are unable to keep your scheduled appointment time, **please call our office at least 24-hours in advance in order to avoid a missed appointment fee**. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients. **If you fail to give us notice prior to missing your appointment, you will be charged the full appointment fee.** No future appointment will be scheduled, except in emergent situations, until this fee is paid.

- If you miss 3 appointments without 24-hour notice, you will be notified by letter, sent to your current address on file, that your chart will be closed. You will not be allowed to make an appointment for one full calendar year with this office. If at that time you wish to be seen by this practice, you will need to re-establish care as a new patient and have paid for all missed appointments.

(Over →)

14 Monckton Blvd Suite 100 A
Columbia, SC 29206
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www.SouthernPsychiatrySC.com

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Please provide a valid Credit Card number to be kept with your file. Note this Credit Card will not be charged except in the event of a missed appointment. All missed appointments will result in a phone call to you from this office prior to charging of the Credit Card. As missed appointment fees are **not** covered by insurance, a health benefits card cannot be used for this purpose.

Name on Credit Card: ______________________________
Type of Card: ______________________________

Card Number: ______________________________
Date of Exp: ______________________________

CVV: ______________________________
Billing Zip Code: ______________________________

I understand that my Credit Card will only be charged if I miss an appointment without 24 hours notice.

By signing this form, I certify that I have read, understand, and agree to this policy.

______________________________ ______________

Patient/Guardian Signature **Date/Time**

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Print Name

Thank you for your cooperation and promptness concerning this matter.