PATIENT FINANCIAL AGREEMENT

Thank you for choosing Thrive Mental Health for your care. We are committed to the success of your treatment and care and realize that communication is vital to the patient's well-being. A mutual understanding is part of our relationship, and we need your assistance and understanding of our financial agreement.

It is important for you to understand the terms of your health insurance policy. Your policy is a contract between you and your insurance carrier. Patients are responsible for knowing which facility is participating with their insurance carrier regarding physicians, hospitals, and outpatient testing.

Participating Insurances: Valid health insurance information must be provided to us to ensure appropriate reimbursement for your care. We participate with many managed care plans offered. If your insurance does not pay 100%, you will be responsible for any deductible, co-payment, coinsurance, and any non-covered services.
Non-Participating Insurances: Valid health insurance information must be provided to us to verify if your policy has "out-of-network" benefits. You will be responsible for any balance over the reasonable and customary charges arbitrarily determined by your insurance carrier, in addition to a higher deductible or co-insurance level.
Secondary Insurance: As a courtesy we will bill your secondary insurance. Valid health insurance information must be provided to ensure transferring and billing of balances after receiving your primary carrier's reimbursement.
Referrals: It is your responsibility to bring any required referral for treatment to your visit.
Co-Pays: Co-pays are due at the time of service. A debit or credit card will be kept securely on file for these costs PRIOR to your appointment. If you are unable to pay your co-pay a $10.00 surcharge will be applied to your account.
Self-Pay: If you do not carry insurance - payment is expected at time of service.
Missed Appointments: We request if you are unable to keep a scheduled appointment that you cancel no later than 24 hours prior to your appointment time. The first time you fail to cancel your appointment, as a courtesy, we will contact you to reschedule, the second time you miss an appointment you will be charged a $100 "no-show" fee, and the third time you miss an appointment you will receive a letter discharging you from the practice.
Balance: Patient balances will be due in full after 30 days unless prior payment arrangements have been established. Accounts are considered "past-due" after 60 days and subject to collections after 90 days.
Collections: Any patient that has been placed in collections must pay any outstanding balances owed along with the collection agency fee to the practice before an appointment will be scheduled or services provided.
Form Completion: Most forms are completed within 7-10 business days. The charge for forms to be completed outside of an appointment time is $150 and expected prior to form completion.
Payment Plans: Our office will be happy to work with you in order to pay any balance due to our practice. Payment Methods: We accept cash, check, American Express, MasterCard, Visa and Discover. You may also pay your bill online at

Refunds: Refunds are issued to the appropriate party. Refunds will not be processed until an account is paid in full.

By signing this document, I _____, have fully read and understand the financial agreement of Thrive Mental Health. I hereby consent to allow Thrive Mental Health to reach me via: (circle all that apply) Home phone (_____) _____-_____ Cell Phone (_____) _____-_____Work Phone (_____) _____-_____

I will cooperate with the billing agency of Thrive Mental Health to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial agreement may be amended at any time without prior notification to me, the patient. If the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

_____
Printed name of patient / parent / guardian

_____ _____
Signature of patient/parent/guardian Date