3500 N. Causeway Blvd. Ste. 1410
Metairie, LA 70002
Phone: (504) 838-9919
Fax: (504) 834-3101

POLICY STATEMENT

Co-payments and/or other fees are required at the time of the visit.

Please initial the following:

_____ 1. This office will make reasonable efforts to collect from insurance companies or behavioral health organizations, but the ultimate responsibility for payment lies with the patient or guarantor.

_____ 2. Appointments must be cancelled with at least 24 hours' business day notice. Monday appointments must be cancelled by Friday. **THE FULL STANDARD FULL FEE WILL BE CHARGED FOR LATE CANCELLATION OR FAILED APPOINTMENTS**.

_____ 3. A reminder call **MAY** be made as a courtesy, but the **FAILURE OF RECEIVING A RENNMINDER CALL DOES NOT EXCUSE A MISSED APPOINTMENT.**

_____ 4. Most insurance companies, including Medicare, will **NOT** pay for billing fees, prior authorizations, telephone consults, reports, letters, forms, missed appointments, NSF fees or collection fees. **THESE STANDARD CHARGES ARE THE RESPONSIBILITY OF THE PATIENT OR GUARANTOR.**

_____ 5. Patients with two missed appointments or late cancellations may be subject to discharge from the practice.

_____ 6. A fee of $45.00 will be charged for all NSF checks returned.

_____ 7. Standard fees will be incurred for prescriptions not written at the time of the appointment.

_____ 8. Standard charges will be made for letters, prior authorization for medications, form and/or reports requested from the doctor or therapist.

_____ 9. The patient or guarantor is responsible for notifying our office of any changes in name, address, telephone or insurance information.

_____ 10. CIFC is a practice management company. Each provider is an individual practioner with no shared liability. With the exceptions of record copying, payments should be made to the individual provider.

By signing below, I acknowledge that I have *read and understand* this policy.

_____ _____
Signature of Patient or Guarantor Date

I authorize_____to release to the insurance company, managed care company, or its representative any information including diagnosis and record of treatment, insurance audit or examination rendered to me during the period of such care.

I also authorize and request my insurance company to pay directly to the provider the amount due me in my pending claim for basic services rendered. If the company does not honor their contract, I WILL BE RESPONSIBLE.

_____ _____
Signature of Patient or Guarantor Date