SYNAPSE
INTEGRATED PSYCHOLOGY

FINANCIAL AGREEMENT

Insurance Benefits:

____ I assign and authorize payment of all insurance and health care benefits available to me directly to Synapse Integrated Psychology (SIP) for services provided to me. **This includes insurance coverage that I have not disclosed to SIP.**

____ I understand that I am responsible for maintaining my own insurance coverage. I agree to inform SIP immediately if my insurance coverage ends or changes. I understand that if I fail to notify my provider or SIP of a change in my insurance and I attend a visit which is not covered, I am responsible for the charges. I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. **This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve**. I further understand that balances due must be paid in a timely manner to avoid further collection action.

____ I understand that the estimated costs for non-covered sessions depend on insurance, length of visit, and complexity. They may range anywhere between:

Assessment:	$125 - $325	Therapy:	$80 - $225
Medication:	$60 - $270	Testing:	$200 - $1100

____ I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided and/or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan).

____ My eligibility and coverage information has been reviewed with me and I understand what my financial responsibilities will be for my visits at SIP.

____ On ___________(date) my unmet deductible was ____________. I understand that I am responsible to pay for visits until my deductible is met.

Returned checks. A $50.00 fee will be assessed on all returned (bounced) checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice.

Patient Name: ______________________ *Patient Date of Birth:* ______________________

Patient Signature ______________________ *date* ______________________

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Optional Credit Card authorization:

Synapse Integrated Psychology has the technology to save credit card information using a third-party encrypted token. With your permission, we can save your credit card to your file without having access to your card number or other sensitive data. For purposes of convenience, you have the following options:

I (print name) ___________________________________ give permission to the staff at Synapse Integrated Psychology to use the card saved to my file to (check all that apply):

❒ Automatically pay my co-pay for each visit

  ❒ I would like a receipt sent to my email address

❒ Automatically pay off my full balance including no-show fees and claims denied by insurance

  ❒ I would like a receipt sent to my email address

OR

❒ Please get my verbal permission prior to every charge processed at Synapse

Permission may be revoked at any time by texting, emailing, or calling the front desk.

Patient Name: ______________________________ *Patient Date of Birth:* ______________________________

Patient Signature ______________________________ *date* ______________________________

For office use only:

❒ Authorization entered into chart by _________

Preferred card: (nickname) _____________________________