RUDOLPH BOLLING PSYCHIATRY, P.C.

201 Beacon Parkway West, Suite 201 Office (205)948-7129
Birmingham, AL 35209 Fax (844)270-4926

FINANCIAL AGREEMENT

Patient's Name _____ DOB _____

Thank you for choosing Rudolph Bolling Psychiatry, PC (RBP) to care for your loved one's mental health! This is our financial policy, which we hope will answer any questions you may have, and will specify the financial contract for our work together. Please review this policy, ask questions as necessary, initial to the left of **each** statement, and sign the agreement. A copy will be provided upon request.

_____ We proudly accept Medicaid, ALL Kids, and Blue Cross/ Blue Shield of Alabama. However, if you have another insurance, are self-pay, and/ or are not covered at the time of service, our **INITIAL EVALUATION session is $300, and each FOLLOW- UP session is $150**. **Payment is due at the time services are rendered.**

_____ Prior to your first/ initial session we will contact your insurance company/ Medicaid to determine benefits, authorization, co-pay, and if a referral is required. We CANNOT GUARANTEE the accuracy of the information we receive. We recommend that you contact your insurance company to confirm this information as you will be responsible for any charges if there is any difference in the actual reimbursement.

_____ If the patient has Medicaid, a form verifying Early and Periodic Screening, Diagnostic and Treatment (**EPSDT**) services or a "referral" is required from the Primary Care Provider (PCP) before the initial session and each year thereafter. It is the responsibility of the patient/ guardian to request this form from the PCP, and to make sure services are not rendered if it is out of date. **THE RESPONSIBLE PARTY WILL BE BILLED FOR ALL SERVICES PROVIDED WHEN THERE IS NOT AN UP-TO- DATE EPSDT/ "REFERRAL" ON FILE.**

_____ If your insurance/ Medicaid is not active on the date services are rendered, you will be held financially responsible for the visit.

_____ No appointments will be made, prescriptions written, or medical records released if there is a bill balance.

_____ Bills that are more than 90 days overdue may be forwarded to a collection agency and reported to the credit bureaus.

_____ We participate in Medicaid, ALL Kids, and Blue Cross/ Blue Shield of Alabama. It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for services rendered, you will be responsible for the balance.

_____ We accept cash, checks, and certified checks. A service fee of **$40** will be charged for all returned checks.

I hereby authorize Rudolph Bolling Psychiatry, PC, hereafter known as RBP, to file all medical claims with any and all insurances in which RBP participates. I hereby authorize payment of insurance benefits to be made to RBP. I further understand that if my insurance company denies any or all medical services as "non-covered", "coverage terminated", "pre-existing" or "not a covered member", I will be responsible for full payment within 30 days of said denial(s), or within 30 days of the first billing statement sent by RBP following the receipt of said denial(s). I understand that RBP does NOT file supplemental, secondary or tertiary claims EXCEPT where RBP participates with BOTH the primary and secondary coverages. I understand that I will be legally responsible for all collection costs associated with the collection of this account including court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance. **I fully understand the above policies and agree to be financially responsible for any and all incurred charges for this account.**

_____ _____

Signature of parent/ guardian/ responsible party/ adult patient Date