Central Jersey Behavioral Health. LLC

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OFFICE POLICY

Our goal is to provide and maintain a provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial*. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see you/your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate **24-hour** notice. **There is a charge of $50 for missed appointments.**
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, **emergencies do occur** and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an appointment, check with your insurance company as to whether the visit will be covered. **Outpatient mental benefits can sometimes be channeled through a different vendor**. Please make sure that the provider you are scheduled to see participates with your insurance/3rd party vendor.

Initial: _____

Insurance Plans

Please understand

1) It is **your responsibility** to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) Insurance companies deny to the most petty little information that does not match with their records. **Please make sure if you are enrolled with two insurances, declaration of primary and secondary are all made clear for both coverages.** Subscriber information should also be correct to avoid denials. **Coordination of benefits should be called in to your insurance every beginning of the year with your insurance if 2 policies are active.**
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and limitations. For example
    a. How outpatient visits are allowed per calendar year.
    b. The maximum amount allowed per calendar year.
    c. Biologically based diagnosis exclusions.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether pre-authorization is required prior to a procedure, and what services are covered.
5) Please be reminded that **coverage with your insurance is a contract between you the subscriber and the insurance carrier.** Our office only follows what your policy states. **If you believe that benefits were not followed accordingly, it is best to contact your insurance carrier to clarify issues.**

Initial: _____

Financial Responsibility

1) According to your insurance plan, **you are responsible for any and all co-payments, deductibles, and coinsurances.**
2) **Co-payments** are **due at the time of service**.
3) **SELF PAY PATIENTS** are expected to pay for services in **FULL at the time of the visit.**
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 14 business days of your receipt of your bill.
6) **If previous arrangements have *not* been made with our finance office**, any account balance outstanding longer than 28 days will be charged a **$10 re-bill fee** for each 28-day cycle. Any *balance outstanding longer than 90 days will be forwarded to a collection agency.*
7) For scheduled appointments, prior balances must be paid prior to the visit.
8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
9) We accept cash, checks, Visa, and MasterCard credit and debit.
10) A $35 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms

1) There is a charge for disability forms and medical letters if the provider spends more than 10 minutes filling up the forms. Present your forms to the front desk and the fee will be assessed based on the extent or how involved the paperwork would be.
2) **Turn around time** for giving back paper work is **7 business days**. Coordinate with the front desk if you would like to speak to your provider regarding your paper work. Your Provider **can demand** for an appointment from you in filling up your forms.
3) Our office **does not** fill up disability forms **within just 1 visit**. **Our providers require about 4-5 visits from the client before filling up forms for disability.**

Initial: _____

Transfer of Records

1) If you transfer to another provider outside our office, we will provide a copy of your records and your last visit to your provider. We need 72 hours' notice.
2) A copy of your complete record is available for a $2-per-page fee.
3) A release records form agreement should be signed by you before our office release your records.

Initial: _____

Prescription Refills

1) For monthly medication refills, **we require 72 hours' notice**, during regular business hours. **If your provider prescribed you a controlled substance, please make sure that your appointment is at a 3 week interval otherwise instructed by your prescribing provider. Please plan accordingly as our office will not be held responsible if you ran out of your medication/s.**

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____