Patient Information

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Birth Date: _____ Sex: _____ Social Security #: _____

Marital Status: _____ Spouse Name: _____

Primary Care Physician: _____ Physician Phone: _____

Referred by: _____

Employer: _____ Employer Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

PRIMARY INSURANCE

Name of Insurance Company: _____ Phone: _____

Address: _____
(City) (State) (Zip)

Policyholder's Last Name: _____ First Name: _____ MI: _____

Address: _____ Phone: _____

ID No.: _____ Group No.: _____

Policyholder's Social Security #: _____Sex:____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Insurance Effective Date: _____

Employer's Name: _____ Phone Number: _____

SECONDARY INSURANCE

Name of Insurance Company: _____ Phone: _____

Address: _____
(City) (State) (Zip)

Policyholder's Last Name: _____ First Name: _____ MI: _____

Address: _____ Phone: _____

ID No.: _____ Group No.: _____

Policyholder's Social Security #: _____ Sex: ____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Insurance Effective Date: _____

Employer's Name: _____ Phone Number: _____

Financial Policy

Thank you for choosing Vista Behavioral Health Associates as your behavioral health care provider. We are committed to providing you with the highest quality of care at competitive prices. In order for us to continue to do this, it is very important that you review the Financial Policy that all patients are required to read and sign prior to their treatment.

Patient Information Form - Please provide all of the information requested on the Patient Information form**.** Some of this information will help ensure correct billing to your insurance carrier. Some will allow us to contact you in the unlikely event that your appointment needs to be canceled. It is your responsibility to inform us immediately if any of this information changes. It is particularly important that you notify us of any changes in your insurance coverage. If you do not do so, we may not be able to obtain authorizations or file claims within your insurance company's timely filing deadlines. In that event, any unpaid fees will become your responsibility.

Insurance Plans - We participate with most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to make sure that your policy covers our providers and services. In some cases, insurance companies require preauthorization prior to your seeking treatment.

Benefits Interpretation - We will do our best to help you interpret your health care benefits, but it is ultimately your responsibility to understand which services are covered and which are not. If you have any questions about this, please ask your provider for help.

Billing Your Insurance - If we are participating providers for your insurance plan, we will bill the insurance company for you. If we are not, or if you do not have insurance, you will be expected to pay for your services in full at the time of your visit. We accept cash, personal checks, or credit card payments. There is a $25 fee for returned checks.

Copayments, Coinsurance & Deductibles – These charges must be paid at the time of your scheduled appointment.

Balances After Your Insurance Has Paid - If there is a balance after your insurance(s) has paid, you are responsible for payment of this balance. If we know what this balance will be at the time of your appointment, you are expected to pay at that time. Otherwise, we will send you a statement in the mail. Payment is due upon receipt. Disputes about reimbursements must be resolved between you and your insurance company. Vista reserves the right to discontinue services to you if your account is more than 30 days past due or if payments owed at the time of service are not paid. Accounts more than 90 days past due or with undeliverable addresses may be forwarded to a collections agency for recovery. A $30 collections fee will be added to account balances forwarded to a collections agency.

Account Responsibility - It is our policy to bill the patient or patient's guarantor for any balances left on the account. If the responsible party fails to make timely payments on the account, we reserve the right to discontinue treatment. If you do not have insurance, you are personally responsible for your own debt and payment is expected at the time of service. In the case of minor patients, the adult signing this form is responsible for all patient balances, including payments due at the time of service.

Appointment Responsibility - If you need to change your appointment, we require at least 24 business hours notice to avoid a charge. The charge for a missed appointment or late cancellation is up to our full fee for the service that was scheduled. This charge will be due prior to the next scheduled appointment or upon receipt of an invoice, whichever is sooner.

Questions About Your Bill - If you have questions or require information about your bill, please contact our billing department at (412) 206-0135 between 7 am and 4 pm Monday through Thursday.

Patient Information & Financial Policy Signature Page & Authorization of Payment of Benefits

I have completed Vista Behavioral Health Associates' Patient Information form to the best of my ability with accurate information, including insurance policy details. I have read Vista's Financial Policy and agree to its terms.

I request that payment of authorized benefits be made to Vista Behavioral Health Associates for any services provided to me or to another for whom I am guarantor or legal guardian. I understand that I must promptly notify Vista of changes to my insurance coverage or to the coverage of the person for whom I am guarantor or legal guardian. I acknowledge that I am financially responsible for the payment of deductibles, coinsurance, copayments, and any other charges not paid by my insurance plan or the insurance plan of the person for whom I am responsible, including any non-covered charges, such as missed appointment fees. I authorize the release of medical information to the insurance carrier and its agents for the purpose of determining which of these services are covered.

Authorization must be signed by the patient or by an authorized person when the patient is a minor or is physically or mentally challenged.

_____ _____

Signature Date

_____ _____

Print Full Name Relationship to Patient

If not patient:

_____ _____

Street Address Date of Birth

_____ _____

City State ZIP Social Security Number