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

FAQs About Vista's Late Cancel/No Show Policy

What is your policy on missed appointments?
If you do not appear for your scheduled appointment, or if you cancel your appointment with less than twenty-four business hours notice, we charge a late cancel/no show fee equal to Vista's full fee for the service.

Why do you charge fees for missed appointments?
When you make an appointment, you are reserving a particular block of time with your provider. This time is reserved for you and no one else. When you fail to appear for a scheduled appointment, or you do not give us sufficient notice to schedule someone else in your place, valuable treatment time goes to waste. And since your provider is a professional who is reimbursed on a fee-for-service basis, the wasted time also results in a loss of income for your provider.

Why should I have to pay for a service that I didn't receive?
You are paying for a time that you asked us to reserve for you. We would much prefer that you come to your appointment and receive the service. However, when you don't appear as scheduled, it is not fair to your treating provider, or to other patients who might have used the time.

If I didn't get a reminder call, why should I have to pay a fee?
For some services, especially psychiatry, where appointments are often scheduled months in advance, we try to call and remind patients of their appointment times. We provide appointment reminder slips and reminder calls as a courtesy. However, there are times when we are not able to make reminder calls. Ultimately, it is your responsibility to remember the date and time of your appointment, even if you don't receive a reminder call.

Are these fees covered by my insurance?
No. They are the responsibility of the patient, or whoever signs the financial responsibility forms.

When are the fees due?
The fees are due prior to the next scheduled appt or upon receipt of an invoice, whichever is sooner.

Can I dispute a late cancel/no show fee?
Certainly. If you dispute the charge, you should contact us within 30 days of receiving an invoice. It is our policy to forward charges not paid within 90 days to our recovery agency. If this happens, it may adversely affect your credit rating.

What if I have a true emergency? Are you still going to charge a late/cancel no-show fee?
We understand that true emergencies do sometimes occur. Please speak with your provider if you believe that a true emergency prevents you from giving adequate notice or coming to your appointment at the scheduled time.

If I have other questions about this policy, what do I do?
Please speak with your provider or with the secretary in the office where you are seen. They will be able to answer your questions, or refer you to someone who can.

Authorization to Disclose Information to Primary Care Physician and Insurer

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____hereby authorize VISTA Behavioral Health Associates to:
(Print Patient's Name)

Please check all that apply:

Primary Care Physician

_____ Release any applicable information to my Primary Care Physician

_____ Release medical information (e.g., diagnoses, medications, compliance**,** symptom ratings) only to my Primary Care Physician

Primary Care Physician's Name, Address & Phone:

_____

_____

_____

_____ **DO NOT** release information to my Primary Care Physician

Insurer/Managed Care Company

_____ Release treatment plan information to_____
(Insurance/Managed Care Company)
as required for authorization of treatment/payment

Please sign below:

_____ _____
(Patient's or Patient's Guardian Signature) (Patient's Date of Birth)

_____ _____
(Print the name signed above) (Date)