**FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT FORM (revised 7/31/2014)**

**PAYMENT GUARANTEE** –In consideration of services provided by Progressive Psychiatry, P.A., I understand that I am responsible for and will pay the entirety of my bill at time of service. In consideration of services to be provided, I agree to pay Progressive Psychiatry, P.A. in accordance with the most recently published rates of the fee schedule and terms of Progressive Psychiatry, P.A.. I further agree to pay the account in full upon receipt of my billing statement.

**METHODS OF PAYMENT** – Progressive Psychiatry, P.A. seeks to provide multiple convenient methods of payment. In the event of a returned check, a fee of $50 will be incurred, and the balance due plus the returned check fee will be due before the next appointment. In the event of stop payment of a check or stop/disputed credit card payment, I recognize that a fee of $50 will be incurred, and the balance due plus the stop payment fee will be due before the next appointment.

I recognize that noncompliance with the payment guarantee can result termination from the clinic and referral per the referral/termination policy.

**RELEASE AND USE OF PATIENT INFORMATION** – I authorize the release of my medical records, information, treatment and advice and specific health information to:

\_\_\_\_\_\_ AN EMPLOYER/SCHOOL who requests service (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana)

\_\_\_\_\_\_\_ INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for service provided.

\_\_\_\_\_\_\_ EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

\_\_\_\_\_\_\_ COMMUNICATIONS regarding appointments and care via \_\_\_\_\_ email, \_\_\_\_\_\_\_ voicemail.

I understand this information concerning medical/mental health care, advice or treatment may include history and physical diagnosis, laboratory and diagnostic testing, specific information concerning alcohol abuse, mental health, drug abuse, human immune deficiency virus, hepatitis, or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for the payment.

I give consent, authorize release, and assign benefits to Progressive Psychiatry, P.A.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient / Guarantor Signature Date

I revoke my authorization as above and I acknowledge that I am responsible for full payment as above. I also recognize that I am responsible for full payment going forward until a new authorization is signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient/Guarantor Signature Date