MERIDIAN
PSYCHIATRIC
PARTNERS LLC

REGISTRATION (Please print)

Legal Name: ____ ☐ Female ☐ Male

If different than above, preferred name & gender: ________________________________

SSN: __________________________ Birthdate: _______________ Age: ______

Address: ____

City/State/Zip: ____

Telephone: (H) ________________(W) _______________ (C) _______________

Specify if okay to leave a voicemail: ☐ Yes ☐ No

Email: ____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Referred By: ____

Emergency Contact: Name: ____

Relationship: ________________ Telephone: ________________

Employer: Name: ____

Address: ____

Telephone: ________________ Occupation: __________________________

Please Choose One:

☐ BCBS PPO ☐ Northwestern University Student ☐ SAIC Student ☐ Self Pay

Signature: ____ Date: _____________

ACKNOWLEDGMENT OF BILLING POLICY

- Payment is due at the time of service.
- Payment may be made by cash, check or credit card.
- You must provide a credit card number to be kept on file. In the event that a balance is outstanding for more than 60 days, this card will be automatically charged.
- Once an account is more than 90 days past due, it is subject to collections action.
- The fees for initial evaluation and subsequent sessions are as discussed at intake or with your clinician.
- Statements for outstanding balances are generated monthly.
- If your check is returned NSF (non-sufficient funds), a $30 charge will be added to the outstanding balance.
- It is your responsibility to provide the office with up-to-date billing information, including changes to address, credit card, and insurance information.
- Meridian will only bill directly to Blue Cross/Blue Shield PPO In-Network plans.

CANCELLATION POLICY

At least 24-business-hours' notice of cancellation is required to avoid being charged the cancellation fee. If you do not cancel your appointment within the 24-business-hour requirement, you will be charged the **FULL FEE** ($200, $150, or $125 depending on the type of appointment and provider). **Cancellation fees CANNOT BE BILLED TO INSURANCE.**

SIGNATURE

I have read the above information and agree with these conditions.

Signature: ____ Date: _____________

INSURANCE

- Insurance cards are required at every visit. We will verify your insurance coverage at the time of your first visit if possible
- Depending on your insurance, Meridian will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services are due at the time of service. As the recipient of services, you are ultimately responsible for all services provided. Meridian is under no obligation to pursue reimbursement on the patient's behalf.
- If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, it is your responsibility to pay. If payment is not received in full within sixty (60) days, by providing your credit card and receiving provided services, you are authorizing Meridian to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to you.
- It is not the responsibility of Meridian to track your coverage. If there is a lapse in your coverage or you have maxed out your coverage, you are responsible for payment in full of the billed amount. If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number, please inform the office. Not updating your personal information can delay and/or deny your insurance claims. If you have not provided our office with the correct insurance information, you will be responsible for any balance due. Please understand that your insurance is an agreement between you and your insurance company, and all services rendered to you are ultimately your responsibility. Meridian will attempt to notify you when your insurance company fails to pay, but has no obligation to do so.

If you are covered by a Blue Cross/Blue Shield PPO:

- We bill at an in-network level for Blue Cross/Blue Shield PPO plans. All other plans will be covered at an *out-of-network* level.
- It is your responsibility to contact your insurance carrier to discuss your plan's mental health benefits, including any deductibles, copayments, annual and lifetime limits, and if **pre-authorization is required.** We will bill your insurance carrier for you.
- Your copay is due at the time of service.
- You are responsible for all charges not paid by your insurance, including deductibles, copayments, uncovered charges, charges for missed appointments, etc.
- You are responsible for informing the front desk of any changes in insurance coverage.

If you are NOT covered by a Blue Cross/Blue Shield PPO:

- The out of pocket payment is **due at the time of service**.
- After payment has been made, we will provide you with insurance invoices to submit to your insurance.

ASSIGNMENT OF BENEFITS TO DOCTOR

In considering the amount of medical expenses to be incurred I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Provider, and hereby assign and convey directly to Meridian all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

Patient/Guardian Signature: _____________________________ Date: _______________

APPOINTMENT REMINDER

I would like to receive a reminder for upcoming appointments and authorize Meridian Psychiatric Partners, LLC to notify me via:

☐ Text ☐ Email ☐ Phone

Phone or e-mail for reminders: ____

____ PATIENT INITIALS

MERIDIAN
PSYCHIATRIC
PARTNERS LLC

MERIDIAN CREDIT CARD AUTHORIZATION

I, _____________________________________, hereby authorize Meridian Psychiatric Partners, LLC, to charge my credit/debit card for any account balance that is more than 60 days past due.

____ PATIENT INITIALS

I understand my card will be charged on a regular basis for these amounts. I also understand that in the event my card declines, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges.

I authorize my card to be charged for fees as indicated above.

____ PATIENT INITIALS

Credit Card Number:____
Exp. Date: ____________ **CVV Code** ____________
Billing Address for the Debit/Credit Card listed above:
____
____
Patient Name: ____
Patient Signature: ____ **Date:** _______________

AUTOMATIC BILLING

Additionally, for your convenience, if you wish to have your balance charged to your credit/debit card for any patient responsibility from services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments) after each visit, please check the auto-charge box and initial below.

☐ Yes, charge this credit card for my balance regularly.
____ PATIENT INITIALS

STATEMENT INFORMATION

You will receive statements from Meridian Psychiatric Partners by US mail.

Signature ____ Date _____________________