SENDAN CENTER
excellence in child & adolescent mental and behavioral health

4201 Meridian Street, Suite 113
Bellingham, WA 98226
www.SendanCenter.com
p 360.305.3275
f 360.734.5503

Sendan Psychiatry & Psychotherapy Financial Agreement

Patient Name: _____ DOB:_____

Please read the policies below carefully before signing.

- Payment is always due at the time of service. If a minor or dependent child is seen without a parent present, arrangements should be made in advance for payment of any charges due on the day the child is seen.
- Sendan Center is only a preferred provider with Regence BCBS, HMA, Premera, Lifewise, Kaiser, and Molina. If you provide us with complete and accurate information, we will bill those insurance companies for you.
- When you have any changes to your insurance, we must be notified before any further visits are billed. Any balance that accrues as a result of changes we are not alerted to will be the full responsibility of patient/guarantor. If you have any other insurance than those listed above, you are responsible for the full cost of the visit at the time of service.
- Any patient responsibility remaining after visits are processed through your insurance (such as coinsurance or deductible amounts) will be billed to you and will be due by the end of the following month. A $5 late fee will be added to any balance remaining at the end of the billing cycle (30 days after billing statements are sent out).
- In order to receive services, we require that an active and valid credit or debit card be kept on your account at all times, even if your insurance will be covering your visits in full. You may change or update this card at any time via your patient portal account or by contacting our billing department. We will not charge your card on file without 1) attempting to contact you at least once by phone and 2) sending you at least one billing statement showing the amount owed, unless you give us explicit permission to charge your card for any outstanding balances without notifying you first.
- We charge for visits missed or cancelled with **less than <u>48 hours'</u> notice.** We cannot bill insurance for missed appointments, and insurance will not reimburse for missed appointments; you are responsible for those charges.
- If more than one person is financially responsible for paying for the patient's visits (eg. if there is a parenting plan in place saying that parents split all costs for medical bills), the responsible billing parties will need to negotiate division of payment between themselves. Sendan Center is not able to enforce any agreements made between the responsible parties and/or other organizations, and we are not able to mediate these negotiations.
- *If the patient is 18 years or older:*
  The state of Washington requires us to make individuals over 18 individually responsible for their bills unless we receive written agreement from their parent/guardian to cover the costs. By signing and completing the information below, you accept full responsibility for all charges not paid by insurance.

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Credit Card Authorization

Please select at least one of the following options:

☐ I authorize Sendan Center to charge my card on file for any copay amount due at time of service

** Please select this option if your child will be checking in for appointments without a parent present*

☐ I authorize Sendan Center to charge my card on file weekly for any outstanding balances

** Select this option if you want balances charged automatically without receiving a billing statement*

☐ Always contact me before charging my card on file for any outstanding balances

If you plan to keep multiple cards on file and you want them charged under specific conditions, please explain below
(Ex: "Charge the HSA card ending in ---- for psychiatry visits and the card ending in ---- for learning services visits" or "Charge the card ending in ---- first, if that card declines charge the card ending in ----")

_____

_____

_____

Please complete the following information for the primary person responsible for billing and payments.

Name of Guarantor: _____ Relationship to patient: _____

Mailing address: Street: _____ unit/apt #: _____

City: _____ State: _____ ZIP Code: _____

Phone number: _____ May we leave detailed messages at this number? ☐ Yes ☐ No

Email address for receipts (optional): _____

I understand that by signing below, I accept full responsibility for all charges not paid by insurance, including fees for late cancelations or missed appointments.

I acknowledge that Sendan Center will charge my card on file for any outstanding patient responsibility balances, and that I will be contacted by phone and by mail before my card is charged. I understand that it is my responsibility to contact Sendan Center's billing department to resolve any questions or disputes I may have about my balance before my card is charged.

Guarantor Signature:_____ Date:_____