

**JOAN L. MOREAU, M.D.**

**FINANCIAL POLICY**

Thank you for choosing me as your healthcare provider. I am committed to providing you with quality care. The following is a statement of my financial policy, **which I require that you read and accept prior to treatment.** If any of these policies represent a hardship or raise concerns, please tell me.

**REGARDING INSURANCE AND BILLING:**

**Participating Provider:**

If I am a participating provider with your insurance, I will bill for my services on your behalf. If, for any reason, your insurance does not cover my services, or, for any reason, your insurance refuses to pay, you will be responsible for payment. Copayment is expected at the time of service and will be collected before the appointment. Ask me or my secretary if you have any questions.

If you Blue Cross/Blue Shield plan customarily reimburses you through Major Medical, you are expected to pay for the appointment at the time of service. MENTAL HEALTH benefits are always different from and usually less than other MEDICAL benefits. Please call your plan to understand your MENTAL HEALTH coverage.

**Non-Participating Provider:**

If I am not a participating provider with your insurance plan, payment is expected at the time of service. You will be given a statement which can be submitted to your insurance for reimbursement. Please check to find out if your plan has "out of network" coverage.

If you wish to self-pay for my services, payment is expected at the time of service.

Billing mistakes occur. Please be sure to tell me if you think a mistake has been made.

**MISSED APPOINTMENTS:**

Because the appointment time is reserved exclusively for you, cancellations require 24 hours notice. Psychiatrists schedule patients differently than family doctors. No more than one person is scheduled for a specific time, and a certain amount of time is set aside for each appointment, usually 20 or 50 minutes. Appointments start on time and end on time. If you arrive late, then the length of time for your appointment is less. No one else can be scheduled or seen during the time which has been set aside for you. If you do not come, that time is not used by anyone. Therefore, you may be charged if you do not give 24 hours notice. You, not your insurance company, will be responsible for paying for the missed appointment. Call to cancel just as soon as you know you are unable to come. We may be able to fill the time with another patient in less than 24 hours notice. If so, you will not be charged for that time. You may leave a message at any of my telephone numbers at any time should you need to cancel. If you are charged, the charge for a missed 20-minute session is \$55.00 and the charge for a missed 50-minute session is \$110.00. These charges are about half my customary charges for those time periods.

**CONSENT TO TREATMENT:**

I (the patient, parent, or guardian) agree that it is my liability and responsibility to pay in full for the charges for services on a timely basis but in no case later than thirty (30) days from the billing date. If such account becomes delinquent, I agree to pay all costs for the collection of these charges, including attorney's fees and court costs. Balances over \$300.00 will need to be paid before additional appointments will be made.

I (the patient, parent, or guardian) hereby request healthcare services from Joan L. Moreau, M.D. for myself or my child. I acknowledge and understand that no guarantee or assurance has been made as to the outcome/results that may be obtained from those services. It is possible that worsening can occur as a result of Dr. Moreau's services, although every effort is made not to have this happen.

**My signature, below, indicates that I have read and agree to the above financial policies and statements.**

Patient or Parent/Guardian\_\_\_\_\_

Date\_\_\_\_\_