Midlothian
Behavioral Health Associates
TMS Center of Richmond

First and Last Name: _____ **DOB:** _____ **Sex:** ___M ___F ___X

Preferred Name: _____ **SSN:** _____ **Marital Status:** __Single __Married __Divorced __Widowed

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____ **Ext.**_____

Email: _____ **Appointment Reminder:** ☐ **Call** ☐ **Text** ☐ **Email**

EMERGENCY CONTACT

Emergency Contact: _____ **Phone:** (_____) _____ **Relationship:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

I give MBHA permission to discuss the following with the individual above: (check all that apply)

☐ **Appointments** ☐ **Billing** ☐ **Treatment/Medication**

OFFICE POLICIES

Full payment for professional services is due at the time of services. If you are unable to pay your co-pay or deductible, you may be asked to reschedule your appointment. We do require a credit card be on file at all times. Please see financial agreement for full terms. **Declined cards for telehealth appointments**: If your card on file is declined for your copay at the time of your telehealth visit, you will not receive your link to your appointment. This may result in the "missed appointment fee" and you must pay prior to scheduling your appointment going forward. **Any patient with a balance over 90 days must pay the balance in full** before an appointment can be scheduled. **Tardiness:** Please call if you running late. Patients arriving more than 15 minutes late may be asked to reschedule. **Cancellations:** If you are unable to keep your appointment, please contact our office at least 24 business hours prior to the scheduled appointment time. **Patients that do NOT contact the office within the 24 hour period to cancel their appointment will be charged a $50- $125 fee for the missed appointment**. We will be unable to schedule future appointments for patients having ***multiple missed appointments and/or cancellations without appropriate notice.*** **Medication Refills: medications require a follow up appointment to be refilled**. If you find that you are running low on a medication, please call our office and we will address the situation. **Returned Checks/Declined cards**: Will be processed with a service charge of $40. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. **Paperwork Charge:** $50 charge for paperwork, reports, etc. Requests exceeding (2) pages may incur additional fees. These paper work requests will take up to the allowed 10 business days from the date we receive written request. A charge of $5.00 may be applied for medical records requested by the patient. Record requests can take up to 15 days after receiving a signed release of information. If records are requested to be sent through email, the release of information must state that specifically with the email address. **Insurance/Referrals:** As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. In the event that you are seen without the proper referral/authorization as required by your insurance, you will be responsible for payment of all fees/services rendered. **Subpoena for Witness:** If any of the providers are subpoenaed for court, the fee is $250/hr. for a minimum of 4 hours. This fee includes preparation time, travel, waiting, testifying, etc. Additional fees may be assessed if travel out of the immediate area is required. Payment in full is required 7 business days in advance of the scheduled hearing. This fee continues to apply even if the provider does not testify. Additionally, fees will remain in effect in the event that court is canceled, continued, or rescheduled less than 3 business days prior to the court appearance for any reason. (e.g. weather, the judge cancelling the day, settlement of the case outside of court, etc.). By signing this, you are authorizing release of information, including financial information and confidential health information and medical records for services rendered regarding your condition, which may include records related to treatment for substance abuse to your insurance carrier(s), managed care plan or other party, past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law**.** In your capacity as a patient, legal representative or representative payee for the patient, you agree to pay all the charges for which you may be legally responsible including but not limited to health insurance deductibles, co-payments, and non-covered services. In the event your account must be placed with an attorney or collection agency to obtain payment, you agree to pay reasonable attorney's fees and other collection costs. Any behavior, words, or actions towards staff or providers that are disrespectful, hostile or harassing will not be tolerated. Failure to comply with any of the office policies may result in discharge from the practice.

By signing below I certify that I have read and understand MBHA's office policies.

Patient/Guardian Signature: _____ **Date:** _____

PAYMENT AGREEMENT & AUTHORIZATION

By signing this document I, the undersigned, indicate that I have fully read and understand the Financial Policy of Midlothian Behavioral Health Associates, LLC. I agree to cooperate with the billing department of this practice to ensure payment for services I receive. I further understand that I will be responsible for the cost(s) associated with the collection of my account if I default on this agreement.
The terms of this policy may be amended at any time without prior notification.
MBHA requires a credit card on file for all patients. Copay's and self-pay rates will be processed the morning of your appointment. I understand that it is my responsibility to update my card on file. If my card declines, will be required to pay my visit amount prior to scheduling going forward. Balances over 90 days will be processed automatically unless a payment plan is made with the billing office.

Cards may be processed for the following:

- Copay's/Self-pay rates
- No Show/Late cancel fees $50-$125
- Paperwork $50
- Refill's outside of your appointment $15 *terms apply
- Balances over 90 days old
- After hours provider call $70
- Records Request

I have read and understand all of the above.

Full Name: _____ DOB: _____

Signature: _____ Date: _____