Premium Psychiatry Service of Central Jersey, LLC

# Patient- Physician Authorizations and Agreements:

Patient name: _____ DOB: _____

Financial Responsibility: I understand and agree to each of us is responsible for the patient's fees to Dr. Ankur Desai. These charges include, but are not limited to, any fees incurred due to unpaid balances, reasonable collection and court costs will be paid by the undersigned; any balances outstanding after 90 days will be submitted for collection. We are responsible for full therapy fees resulting from appointments not kept or cancelled without a 24- hour notice. I understand that the services must be paid at the time services are rendered, and I am responsible for filing for the insurance reimbursement. I understand that if the case is submitted for collection only the demographic information and payment information will be share with the collection agency.

Release of information: I authorize Dr. Ankur Desai to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instruction to Dr. Ankur Desai to the effect, which I may do at any time.

_____ _____

Patient/ Parent signature Date

_____ _____

Responsible party's signature Relation to patient

**PLEASE INFORM ANY OF OUR OFFICE STAFF IF YOU HAVE MEDICARE OR MEDICAID AS YOUR PRIMARY INSURANCE.**

Third party payment: I understand that the following is the agreement between Dr. Ankur Desai and _____.

_____

_____

_____

I am responsible for charges incurred due to any missed session. I am aware of the charges that I would be responsible for, after the third party contract is completed.

_____ _____

Patient/ Parent signature Date

_____ _____

Responsible party's signature Relation to patient

Modified: 12/20/12