PATIENT CONTRACT

Please read and sign below acknowledging that you have read, understand, and agree to the terms in this contract.

OFFICE HOURS: Our office hours are Monday to Friday 8:00 am– 5:00 p.m.

APPOINTMENTS: Please see the late cancellation/no-show policy. All fees must be paid before future appointments can be scheduled.

EMERGENCY CONTACT NUMBERS: We are an out-patient practice. The emergency phone numbers provided on the office voicemail are for after-hour urgent issues that are not life threatening. If you are experiencing a life-threatening emergency such as violent or suicidal thoughts you must call 911 immediately. **Patients who choose to contact a provider after hours for a non-emergency will be billed for a phone consultation. Phone consultations are not paid by insurance companies.**

PRESCRIPTION REFILLS: All prescription refills are handled during appointments exclusively (NOT BY EMAIL OR TELEPHONE).

INSURANCE & PATIENT RESPONSIBILITY: It is the patient's responsibility to notify us with any insurance changes and to obtain any required authorizations. Our office will submit claims to the insurance company we have on file. Per our contractual agreement with insurance companies we must collect all co-payments and/or deductibles due from the patient. Co-payment and/or deductibles are due at the time of service unless other arrangements have been made in advance. **Should the insurance company not cover the service, the balance may become payable by you. Any balance due from the client that is not paid within 90 days will be referred to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection effort.**

RELEASE OF RECORDS: All patients or their parent/legal guardian must sign a release authorizing the release of any information. No information will be released without a properly executed consent. Record request may take up to 30 days to process and pre-payment is required.

FEES NOT COVERED BY INSURANCE: Fees for the items listed below are not covered by insurance companies and are the patient's responsibility. Fees for these items must be paid at the time the service is rendered and prior to the next scheduled appointment.

- Fees for medical records sent to attorneys or other agencies
- Fees for no shows or cancellations less than 24 hours before the appointment
- Fees for returned checks
- Fees for disability forms, FMLA forms, or letter preparation

REASONS FOR TERMINATION: The reasons outlined below are common reasons for termination from our office. This list is not comprehensive and the treating provider has final authority on terminating treatment.

- Continuously canceling or not showing for scheduled appointments
- Not following the recommended treatment plan
- **If the patient is not seen within 6 months, unless otherwise instructed by your provider, your file will be closed (voluntarily terminated) and no prescriptions will be authorized for refills until you are seen.**

CONFIDENTIALITY: In accordance with moral, ethical, and legal guidelines regarding your right to confidentiality, patient's personal information is carefully guarded. However, there are some exceptions which must be noted:

- If a patient poses a threat to his or her own safety or the safety of others, we are required to notify concerned parties and the authorities.
- If a patient reports actual or suspected abuse of any individual, our office must notify the proper authorities.
- In patient groups of two or more, including the lobby and check-out, confidentiality is urged but not guaranteed.

AUTHORIZATION & SIGNATURE ON FILE: By signing this form, I authorize **Scottsdale Mental Health & Wellness Institute** to release all necessary information to insurance companies to process claims or obtain authorization for treatment. I authorize payments be made to **{Enter Provider Name}** from insurance companies, government agencies, or any other agency providing benefits for services rendered. I authorize that a copy of the signature below may substitute as the original.

I have read, understood and agree to follow all terms and conditions of this contract.

_____ _____

Patient Signature Date

P: 480.508.0882
F: 480.508.0891
www.SMHWI.com
8350 E. Raintree Dr. Suite 130
Scottsdale, AZ 85260