



Neuro Behavioral Center, LLC
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PATIENT TREATMENT AGREEMENT

V1023

Introduction:

The goal of Neuro Behavioral Center LLC is to provide the best possible care to every patient seen at our Center.

This is an agreement between you, the patient, and Neuro Behavioral Center LLC (NBC). It addresses certain conditions with regards to your treatment, the use of your medical records insurance benefits, and other NBC policies. In consideration of receiving NBC services, you agree to the following:

Disclaimer

Neuro Behavioral Center is an outpatient practice and does not provide emergency services.

Our providers will make every possible effort to address all your concerns in a timely manner. However, if you have any urgent or emergency matter, YOU SHOULD CALL 911 IMMEDIATELY or go to closest Emergency Room. This applies should you have any serious medication reactions, worsening suicidal thoughts, a suicidal plan or intent or worsening of homicidal thoughts, or any other clinical issues which may require immediate emergency attention.

- I fully understand that Neuro Behavioral Center is an outpatient practice and does not provide emergency services and if I am in need of immediate, urgent or emergency services, I should call 911 or go to closest Emergency Room.

Authorization to Provide Basic Treatment, Conduct Basic and Routine Diagnostic Procedures:

- I authorize NBC to conduct and perform all routine examinations, treatments, and care under the general or specific instructions or direction of my Provider.
- I understand I will be given an appointment for an initial evaluation during which time a provisional diagnosis will be made and a treatment plan will be created and agreed upon with your Provider. After my initial evaluation and prior to my fourth visit, a decision will be made as whether to continue with the current treatment, terminate, refer or transfer care.
- I understand that if I choose not to follow the Provider's recommendation for treatment, I accept the responsibility for any consequences of my decision.
- I understand that by not being an active patient at NBC for over 6 months, I am voluntarily terminating my relationship as a patient at NBC.

Booking, Canceling Or Rescheduling An Appointment:

- To book, cancel or reschedule an appointment, please call the office during our regular business hours or send us a request through your online patient portal. Our automated reminder service will text you to confirm your appointment time two days before your scheduled appointment.
- I understand that I will be given the option to choose to confirm or call back to reschedule or cancel my appointment and will respond accordingly during regular business hours or submit a request through my online patient portal.
- Our automated reminder service will text you to confirm your appointment time two days before your scheduled appointment.

No-Show Policy: *within a 6 Month Period*

Established Patients: Policy for missed appointments without cancellation prior to 24 hours

- 1st No-Show - Warning Letter
- 2nd No-Show - \$100.00 No-Show Fee
- 3rd No-Show - \$100.00 No-Show Fee

After 3rd No-Show will be sent to Management to be reviewed for Practice Termination

New Patients:

*All New Patients must leave a credit card on file when booking a New Patient Appointment.

*You will be notified of your missed initial appointment and you will be charged the \$100.00 No-Show Fee. If the card declines you will not be rescheduled with our practice.

Prescription Refills:

NBC Providers will refill your medication upon your next visit; however, some medications may require insurance approval and a Prior Authorization to be submitted to your insurance company.

- I understand that most medications require an appointment with a Provider before any refills can be authorized, and I am responsible to have booked an appointment before my medication runs out.
- In the event that a medication refill is needed between appointments, I must contact my provider and allow 3 business days to process this request, and 7 days must be allowed for medications requiring Prior Authorization from the insurance company.
- For controlled substance medications, I understand that a separate contract must be signed that will lay out the terms and agreements for prescribing these medications.
- I understand NBC will not accept any pharmacy refill requests either by phone or fax. I must not depend on the pharmacy to send refill requests on my behalf. I understand it is my responsibility to manage my medications and plan accordingly.

Release of Medical Records, Information for Treatment, and Payment Expectations:

Any medical record request should be accompanied with an authorization to release private health information or PHI, and a period of 7 business days is necessary to process your request. NBC provides an easy access to request your medical records through your online patient portal

- I authorize NBC to provide from its records any information and medical records including psychiatric, substance abuse, HIV related or other Confidential Information requested by my insurance/managed care company, Medicare, Medicaid, or other third-party payors, hospital agents or governmental agencies in connection with payment of my bill.
- I authorize NBC and its agents to provide Confidential Information from my medical records to any utilization, managed care, and/or quality review organization affiliated with my insurer/payor or otherwise for use in utilization management. I further authorize NBC to provide Confidential Information to my Primary Care Physician (PCP) to discuss my medical care.
- I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future treatment except where disclosure of the communication and record is necessary for treatment. I understand that if my refusal to provide authorization results in a refusal of my insurer, managed care company or the third-party payor to pay NBC, I will personally be responsible for the bill or the unpaid portion of the bill.
- I understand that my Provider has the right to refuse sharing some or all of my psychiatric/psychological notes with me.
- I understand that NBC will fax/mail any medical records requested by me to another Provider, or to my Authorized Representative, at no additional cost.
- I also understand that I may request my records to be printed and mailed/picked up by me or sent to an attorney, in which case, printing and mailing fees will apply.

Assignment of Benefits/Financial Agreement:

Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. Any fees incurred that are not covered by your insurance will be the responsibility of the patient or responsible party.

- I authorize third-party payers, including insurer, managed care companies, and Medicare or Medicaid and other governmental payers, to make payment directly to NBC.
- I understand that I am financially responsible for payment for services not covered by this authorization, and that I will pay all costs of collection of any delinquent balance including reasonable attorney's fees, which may be added to my account.
- I understand that my refusal to grant authorization to my third-party payors will in no way jeopardize my right to obtain present or future treatment except where disclosure is necessary for treatment but understand that under such circumstances, I will be responsible for paying my bill in full. Upon request, I may receive copies of my charges.
- I understand that it is my responsibility to notify NBC of any patient information changes (i.e., address, name, insurance information, contact, etc.). If current information is not obtained at the time of service, it will become my responsibility to pay the entire balance until current information is provided to your office.
- I understand all copayments, coinsurance or deductibles are expected to be paid prior to my visit in the form of check or credit card.

- I understand when services are provided through a telehealth visit, I agree to have my credit/debit card information securely saved with NBC's health records system, and it is my responsibility to maintain, change and update my card information in order for NBC to automatically process any payment per insurance prior to my appointment.
- I understand for any checks returned, for any reason, a charge of \$50 will be added to my account.
- I further understand that NBC reserves the right to accept periodic installment payments without waiving its rights to demand payment in full.
- I understand that NBC provides easy access to pay my bills and review my statements through my online patient portal.

Private Health Information Confidentiality Policy:

NBC adheres to all HIPAA policies and regulations, and will do its best to protect your Private Health information from being disclosed or shared, unless otherwise specified above.

I have read this Patient Agreement, or it has been read to me, and I understand it. All of my questions have been answered to my satisfaction, and I freely agree to all of the terms and conditions in the agreement that are applicable to me except those specifically noted above.

Today's Date: Medical Record Number

Patient Name: Date of Birth:

Signature of Patient

Date:

Signature of Authorized Personal Representative

Relationship

Date:

If a representative has signed for the patient, please state the relationship to the patient and the reason the patient did not sign on next page.

Reason: