

Salem Psychiatric Associates, P.C.  
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## FINANCIAL POLICY ACKNOWLEDGEMENT

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convenience of our patients we offer the following methods of payment of fees:

- Payment in full by cash, bank card (Visa & Mastercard) or alternate financing of each appointment as service is rendered. Alternate financing (payment plan) must be arranged before treatment is rendered.
- For patients with insurance, we will accept payment directly from the insurance company only for that percentage, contracted rate or allowed amount the company will cover, and do require that the deductible and non-covered fees be paid at each visit.
- There will be a \$25 minimum and up to a \$275 maximum charge for any missed appointment or appointment not cancelled with a **24 HOUR NOTICE**, regardless of reason. The length of time scheduled for you determines the charge. We will not reschedule any patient after two appointments have been missed consecutively. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

Our office staff understands insurance, and will be glad to assist you in obtaining the maximum benefits specified in your contract. *It is important that you realize, however....*

- Your insurance benefit is a contract between you, your employer, and the insurance company. **We are not a party to that contract.** This office files your insurance claim as a courtesy to you.
- Our fees generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier.
- Not all services are a covered benefit in all contracts.
- You (not the insurance company) are responsible to us for all fees for services rendered to you.
- Upon request, a pre-determined **estimate** of benefits can be given to you.
- We will gladly discuss your proposed treatment and answer any questions you might have as to the involvement of your benefit program in receiving this care. **We appreciate the opportunity to serve you.**

*I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.*

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Signature of patient or parent/legal guardian

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Date