****

Effective 5/18/2015 Page 1 of 1

Arizona Advanced Health Services strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide.

**Co-Pays:** We require payment of co-pays at the time of service, and reserve the right to refuse treatment.

**No Insurance:** If you have no insurance, we collect **$200** for your initial office visit, and an estimated **$100** on your follow-up visit. (Pending on time spent in evaluation) (30 min and above 150.00, 15-30 min is 100.00)

**Payments:** We accept cash, Visa, MasterCard, Discover and American Express.

**Cancellations:** A fee of **$75.00** will need to be paid before another appointment is booked if there is either a no-show or a cancellation before 72 hours prior to your scheduled appointment. Notification allows the doctor to see another patient who needs to be cared for that day.

**Claim Filing**: We happily file your claim with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter into disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance.

**Forms/Medical Records**: There will be a **$75.00** fee for forms that a provider completes on your behalf. This is to include but not limited to: Disability paperwork, court paperwork, and placement paperwork. For these types of forms there is a **3 visit minimum** in order for the Dr. to be able to answer the questions accurately. The fee is due before completion of the paperwork. There will be a **$35.00** fee for Medical Records Request.

**Dual Diagnosis**: We are **NOT** accepting any patients with a dual diagnosis. “Dual diagnosis is defined as someone who has **BOTH** a mental illness and a substance abuse problem. If it is found out after we have accepted you as a patient that there is a substance abuse issue, we have the right to refuse treatment.

**Attestation Statement:**

I have read, understand, and agree to the above Payment Policy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign Name Date