NEW PATH PSYCHIATRY

801 W. Mineral Ave # 101
Littleton CO, 80120
Tel: 720-466-1932
Fax: 720-802-7462
admin@newpathpsychatryco.com
www.newpathpsychiatryco.com

Financial Policies & Credit Card Acknowledgement

The following are the financial policies and other important information of New Path PLLC, dba, New Path Psychiatry ("New Path"). Please take time to review all of the following information and sign at the bottom if you agree to be bound by it.

DISCLAIMER: HEALTH INSURANCE MAY NOT COVER YOUR THERAPY OR A PART OF YOUR THERAPY. IT IS YOUR OBLIGATION TO ENSURE YOU HAVE COVERAGE FOR ANY SESSIONS PRIOR TO PARTICIPATING IN THEM. IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE FOR OUR SERVICES, YOU AGREE TO BE PERSONALLY RESPONSIBLE FOR ALL CHARGES INCURRED AS PART OF THE SUBJECT SERVICES. Please verify your health insurance coverage when you arrange your first visit. As the patient, it is in your best interest to know and understand your insurance plan benefits. It is also important that you know your responsibility for any deductible, co-insurance, or co-pay amounts prior to your office visit. You are required to provide all information necessary so we can process your claim in a timely and efficient manner. If your insurance coverage changes during the course of your treatment, you must immediately notify us of that change.
Please know that we are here to help you if you have any questions.

SAME-DAY PAYMENT
Both self-pay and insured patients are required to pay all costs due during each visit in-full at the time of an appointment. These charges may include co-pays, visit fees, additional services, and medicines. If requesting a sliding scale, note that more documentation will be required. Contact the front office for more details. Self Pay rates are **$330** for new intake and **$175** for 25 mins or **$220** for 45 mins follow-up appointments. Please note that you will be required to pay these rates if insurance lapses.

SPECIAL NOTICE: SELF-PAY AND UNINSURED INDIVIDUALS; GFE.
If you are not insured or your insurance company will not cover the visit and there is no deductible to be met, you will be considered a "self-pay" patient. If you are uninsured or are self-pay, you have the right to receive a good faith estimate for the total expected cost of any non-emergency items or services. This includes costs related to tests, equipment, and hospital fees. Please see the disclosure regarding the "No Surprises Act" separately provided to you for more information or contact us for more information.

INSURANCE BILLING ACKNOWLEDGEMENTS

INSURANCE BALANCE: New Path will make all attempts to bill insurance on file. Note that after the charges remitted to a patient's insurance are responded to, any patient balance/deductible owed identified by the carrier will be automatically billed to the credit card [also debit card] on file. All outstanding balances with your insurance must be paid in full prior to your next office visit or receiving supplements.
INSURANCE CHANGES: If your insurance changes during the course of treatment, you must provide this information immediately or prior to being seen at your next appointment. Many insurance companies require

authorization that will not be backdated for any reason. If there is a time lapse between the effective date of your new policy and informing the clinic of your new insurance, you will be personally and financially responsible for any claims that are denied for any reason, including lack of referral or authorization.

IN-NETWORK INSURANCE: Accurate and complete information is required at your first visit. We do not bill insurance for co-pays. If your policy requires a deductible or co-insurance, you are responsible for paying in full at each visit which will be collected 24 hours before your appointment.

OUT-OF-NETWORK INSURANCE: If we do not participate with your insurance company, you will be responsible for payment inf full at the time of service. New Path will provide a superbill for you to submit to the insurance company, if you will like to be reimbursed.

SECONDARY INSURANCE: If you have a secondary insurance company that will provide coverage, it is your responsibility as the patient to submit all information prior to visit. New Path will attempt to submit all claims to the right insurance. Patient is still required to pay all claims in full if denied by insurance

INSURANCE DOES NOT COVER NATURAL MEDICINES/ SUPPLEMENTS: I fully understand that all supplements, vitamins, medical grade food, nutritional powders, botanicals, homeopathic remedies, and cell salts are not covered by insurance.

You should also be aware that most insurance companies require that we provide them with your clinical diagnosis. We may be required to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, New Path has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records we submit to your insurance company if you request it. You understand and agree, by using your insurance, you authorize New Path to release such information to your insurance company. We will try to keep information limited to the minimum amount necessary.

ADDITIONAL FEE POLICIES

At New Path Psychiatry, some services may have additional fees beyond standard session costs or insurance coverage such as charges for specialized services like ADHD testing and genetic testing, which vary based on the service. We will inform you of any applicable fees before proceeding. Payment for these services is expected at the time of the request unless other arrangements are made. Please contact our office with any questions or concerns regarding these charges.

FORM COMPLETION: There is a **$100** fee for completing forms such as school, work, short term disability forms more than 1 page, exemption for Medicaid patient who will be required to be present for a visit for forms to be completed.

MISSED APPOINTMENT FEE: you will be charged **$100** for a missed appointment. This payment is expected to be paid before any further appointments can be scheduled.

RETURNED CHECK: There is a **$50.00** fee for any check returned by the bank.

CREDIT CARD CHARGE BACK:

PAST DUE ACCOUNTS: In the event your account becomes past due, we will take necessary steps to collect the debt. If your account becomes past due over 120 days, your account will be referred to our collection agency. You will be charged for this service in addition to your current account balance. If we have to refer the collection of balance to a lawyer, you agree to pay all attorney fees and costs associated with such collection.

COPIES: Printed copies of lab work, chart notes, imaging, and invoices are billed at **$2.00** per copy. All records requests will be charged a $100 fee.

REFUNDS POLICY: Once medicine samples have physically left the office, we can no longer guarantee the integrity of them. To guarantee the health and safety of patients and the public at-large, medicines dispensed, mixed from New Path CANNOT be returned, refunded, credited, or exchanged under any circumstances. All sales are final. All medicine containers and bottles will be inspected for integrity when they come in and leave the office. We reserve the right to make substitutions on medicines if the brand or dose of the prescribed medicine is not available at the time of purchase. It is your responsibility to communicate if you do not want a substitution and to check the medicines you've received prior to leaving the office with them. There are no refunds of provider services once completed

CREDIT CARD CHARGEBACKS: I understand that initiating a credit card chargeback without first attempting to resolve the issue directly with the clinic may result in a $50 administrative fee. I agree to contact the clinic and allow reasonable time for resolution before disputing any charge with my credit card company. I also understand that repeated or unresolved chargebacks may result in discharge from care, in accordance with clinic policy.

I, the **below-signed individual**, agree to keep a card on file to pay for the costs of all services and charges incurred and authorize New Path **to charge my credit card on file** for all such fees and services provided. I understand a superbill/ receipt will be promptly sent to me upon any payments made using the card on file. I understand I must promptly notify New Path directly if anything changes in my credit card information.

CHOICE OF LAW; VENUE.
By signing below, you understand and agree the law of the State of Colorado shall govern this Agreement, and all consents or other legally binding documents related to your treatment relationship with New Path, without regard to Colorado's choice of law principles. The courts located in Arapahoe County, Colorado shall be the exclusive venue for all disputes arising under this Agreement, relating to New Path services, or your professional relationship with us or our providers, and you specifically waive any challenge or defense to venue in that jurisdiction. Entering the information/ your name below will represent your digital signature. By signing, you acknowledge
that you have reviewed, understand, and agree to adhere to the policies listed above and have been given a reasonable opportunity to review them and ask questions.

FINANCIAL INFORMED CONSENT AND AGREEMENT
I agree to the above financial and cancellation policies. I hereby authorize New Path PLLC to keep my credit card and other form of payment on file and to charge it one week after notice of any balance. In the event of default payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I have read, understand, and accept the information and conditions specified in this agreement

☐ I hereby agree to the document above

_____ _____
Printed Name Date of Birth

_____ _____
Signature of patient or responsible Party Date Signed

If signed by Responsible Party, Please state your name and relationship to or authority to consent for patient:

_____ _____

Name of Responsible Party Relationship/Authority