Synapse Association Inc.
2056 Lyndell Terrace, Suite 130, Davis, CA 95616
Phone (530)924-4038 Fax: (530) 924-4816
www.synapseassociation.com

Patient Services Agreement

Synapse Association, Inc.

Terms and Conditions

1. Payment for Services: It is understood and agreed that whether I am signing as an agent or a patient, I am required to pay in full for services rendered by this office, regardless of whether my insurer covers such expenses. I hereby individually obligate myself to pay the account of this office in full in accordance with its rates and charges. I understand that the designated billing company will mail two statements via USPS to the address I provided, regarding any balance owed.

   Initial: _____

2. Assignment of Insurance Benefits: Whether signing as a patient or as an agent, I authorize direct payment of any insurance benefits otherwise payable to me for my treatment by this office and/or charges relating thereto. I also acknowledge and understand that I remain financially responsible for charges not covered by my insurance provider, for any reason. I acknowledge that insurers do not guarantee payment for rendered services (even when a preauthorization is obtained by the office), for amounts deemed patient responsibility, or for non-covered services. In cases of patient responsibility (es, copayments, or co-insurances) (Refer to page 6 for the office polices and payment details) deductible there will be a 60-day grace period to allow for receipt of payment from the insurer and thereafter I understand that I am solely responsible for the balance owed and will be billed accordingly. I understand that I will be expected to satisfy the balance immediately. Thereafter, I may be subjected to interest charges at the legal rate and treatment may be discontinued immediately.

   Initial: _____

3. Managed Care Plan: It is my responsibility to know and understand my managed care plan. Generally, insurance plans require payment of deductibles and/or co-payments. I understand that if Synapse Association contracts with my insurer, this office will only file patient insurance claims if I provide them with the proper information, along with a copy of my current insurance card and/or other sufficient proof of insurance. In the event that an insurer overpays, this office will

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refund the overpayments to me within a reasonable time after written request. Otherwise, overpayments will be credited to my account for future services.

Initial: _____

4. Termination Policy: I understand that this office has the right to discontinue services at any time, without limitations, for any reason. Reasons may include: failure to attend a scheduled appointment, failure to reasonably communicate or cooperate with the treating physician and staff, and/or failure to comply with prescribed treatment requirements. Likewise, I am aware that my treatment is " at will" and I reserve the right to terminate or refuse treatment (including medication) at any time. While undergoing any treatment, I agree to immediately inform Synapse Association or anything pertaining to or effecting my treatment. I commit to achieving my treatment goals by effectively communication with this office. If there is a lapse of more than 3 month period, other than circumstance Clinician advises a longer period, a letter to schedule an appointment will be sent to me. If I fail to make an appointment within 15 days upon receipt of the letter it will be considered a noncompliance to the doctors' orders, and a second letter will be sent to me notifying me of my discharge from the office.

Initial: _____

5. Prescriptions: I understand that it is my responsibility to keep track of refills of my medications and that I need to contact my pharmacy and the office for refills. I acknowledge that this office requires a seven-day notice for refills for any controlled or pre-authorized medications. The process for refilling medications with this office shall proceed as follows; contact pharmacy for refill, and place a call to office. I understand it is my responsibility to pay for my medications and to obtain a list of medication covered through my insurance policy. I am aware that this office processes prior authorizations as a courtesy to the patients and that is is not a requirement for treatment, nor are there any rules/laws mandating the processing of the medication authorization requests. This office policy is 14 working days for the submission of medication authorizations, in the event there is a denial for an authorization, this office will not seek further actions. The office has discretion to retract this courtesy at any time for any reason without explanation. Requests for authorizations are done only for medications where the cost is more than $50.00 for a 30 day supply. Synapse Association will give timely notification to patients when/if the processing of medication authorizations is no longer available as a courtesy. Any requests given prior to the date of retraction will still be honored and processed accordingly