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

Treatment Polices

Patients are required to agree to the following before any treatment can occur.

1. **Payment for Services:** I agree that I am required to pay in full for the services rendered by this office, regardless of whether my insurer covers such expense. It is understood and agreed that whether I am signing as an agent or a patient, in consideration of the services to be rendered. 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 If there is a lapse in payment exceeding a 90-day period, I understand that my account will be referred to collections and that I will be discharged for nonpayment from the care of Synapse Association and staff. Should my account be referred to collections, I agree to pay the delinquent amount and I understand that interest rates may apply at the legal rate. Payments may be made via heck, cash or credit card and can be paid at the office or by USPS to the office address I and **I understand that is $35.00 penalty fee for any returned (bounced) checks.** I understand that office staff will have no access to account balances**. There is a $25.00 fee for any forms required to be filled out by my provider and I am aware that there is a ten business day allowance for processing and submission of any paperwork from this office.**
2. **Assignment of Insurance Benefits:** Whether signing as a patient or as an agent, I authorize direct payment to this office 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 always pay the full amount for rendered services, including but not limited to: the preauthorization for series, quoted patient responsibility, and provided policy coverage details**. 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 r the balance owed and will be billed accordingly. I understand that I will be expected to make a payment within 10 business days following said grace period.** Thereafter, I may be subjected to interest charges at the legal rate and treatment may be discontinued immediately.
3. **Managed Care Plan:** It is my responsibility to know and understand my managed care plan. Generally, insurance plans require payment of deductions 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 refund the overpayments to me within a reasonable time after written request. Otherwise, overpayments will be credited to my account for future services.
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

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Synapse Association of anything pertaining to or effecting my treatment. I commit to achieving my treatment goals by effectively communicating with this office.

5. **Prescriptions:** I understand that **it is my responsibility to track refill needs on my medications and that I need to contact my pharmacy or this office for my refill needs.** I acknowledge that this office requires a seven day notice of refills for any controlled or preauthorized medications to prevent a lapse in medication. I understand that I am responsible to pay for my medication if it is not covered by insurance provider. I understand that is not the responsibility of this office or the provider to attain an approved medication list and therefor, the provider is unable to prescribe medication based on my pre-approved medications, per my policy. Furthermore, I understand that it is my responsibility to attain a list of approved medications and give it to my provider so that I may avoid a lapse in medication due to the necessary prior authorization approvals for medications which are not covered by my insurance**. I am aware that this office processes prior authorizations as a courtesy to the patients and that is not a requirement for treatment, nor are there any rules/laws mandating the processing of the medication authorization requests. The office policy is 14 working days to submit the request to my insurance company and I understand that in the event there is a denial for an authorization, this office will not seek further actions. It is the right and at the discretion of the provider 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 the medication authorizations are no longer available as a courtesy. Any requests given prior to the date of retraction will still be honored and processed accordingly.
6. **Cancellation policy:** I agree to and understand that per policy at Synapse Association there is a ($75.00 existing patients/$100 new patients) charge for any missed appointments for failing to give notification of cancellations, no less than 48 hours prior to my appointment. If I am more than 10 minutes late for my scheduled appointment, I accept that my appointment will be cancelled and the above charges will apply. If the office is closed for weekend/holiday and a cancellation is necessary, it is acceptable to leave a voice message. I acknowledge that this office does not provide courtesy reminder calls for appointments and I agree that it is my responsibility to attend my scheduled appointments, as well as follow up to reschedule any cancelled appointments. As a courtesy and to maintain the health of the office's patients and staff, Synapse Association allows patients one cancellation (per calendar year, October-February ONLY) beyond the 48 hour time frame and without penalty, if the patient has influenza. I acknowledge that to redeem this courtesy, I am still required to call and inform staff of my absence no later than 2 hours before my scheduled appointment time.

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Print Name Signature Date