Regan Haight, APRN, PMHNP: 12569 South 2700 West, Suite 202A, Riverton Utah 84065

Phone: 801-701-1006 Fax: 801-701-1009 Email: reganhaight@gmail.com Website: www.reganhaightaprn.com

FINANCIAL RESPONSIBILY AND AGREEMENT

Please inform us if you wish to utilize insurance**. It is your responsibility to verify and understand your insurance coverage and obtain prior authorization if needed.** You are responsible for payment for all services provided in this clinic and for any balance that your insurance company does not authorize for payment**.** If we are paneled with your insurance company, we will submit a claim to them once. If they deny the claim, you will be responsible for the cost of the session. If we do not accept your insurance, you will be charged the self-pay rates and we will provide you with a receipt that you may turn in to your insurance company for reimbursement. Your signature below indicates that you give permission for Regan Haight to bill your insurance company for services and to exchange information necessary to secure payment for these services. Such necessary information may include your diagnosis, service dates, types of services and other information related to services necessary to process claims.

Our contracts with insurance companies require us to collect your **copay at the time of service**. If your account is **self-paid**, **all services must be paid for at the time of your visit. If you have an un-met deductible, $85.00 is due at time of service** and the remaining balance will be billed to you after the insurance as sent response of coverage. We accept cash, credit cards, and checks as forms of payment. In the event a personal check is returned unpaid from your bank, your account will be charged a $30.00 returned check fee. We require you to keep a credit card on file so we can collect co-insurances, deductibles, and other unpaid balances as soon as your insurance carrier assigns the appropriate amount of patient responsibility. CC information is kept secure in a PCI compliant system. Your statement will be made available to you through the Patient Portal or mailed to you for a $10 processing fee. If the CC on files expires or otherwise becomes uncollectable, we expect you to promptly provide a new means of payment. If the credit card kept on file does not process, or you choose not to keep one on file, a $10 billing fee will be assessed each statement prepared and mailed out.

All account balances are due upon receipt. Balances greater than 60 days are subject to be sent to a collection agency. Accounts sent for collection action may accrue a collection fee of up to 30% of the balance. Patients will never be denied access to necessary medical services due to a financial issue; however, patients may be discharged from the practice due to delinquent balances. If a patient is discharged from the practice for financial reasons (including bankruptcy), we will give 30 day notice and provide emergency care during that period of time, while a new provider is established for you or your child.

Your appointment time is held specifically for you. An automated appointment reminder is sent as a courtesy to the email or phone number you have on file, but it is ultimately your responsibility to keep track of set appointments. Appointments can be seen in the patient portal. Cancelations need to be made **24 hours in advance** or you will be assessed a $**25 Late Cancellation Fee.** If you fail to show for an appointment, you will be assessed **a $60 No Show Fee.** This will be billed to your credit card at the time of the missed appointment.

Fee for Service Rates/Self Pay Rates:

Initial consultation/evaluation 70-85 minutes-$180.

Medication Management sessions are 20-35 minutes-$85

Psychotherapy visits are 55 minutes-$125

Psychotherapy and medication management sessions for 60 minutes -$150.

Telephone calls and reports preparation are charged at a rate of $30.00/15 minutes

Medical Record transmittal: $25.00

_____ Yes, I would like to receive my account statements through the patient's portal and have my card process automatically for all outstanding balances. (please ensure access to patient portal) **https://www.valantmed.com/Portal/rhaight**

_____No, I would like paper billing statements prepared and mailed to me and agree to pay a $10 billing fee.

I authorize Regan Haight PLLC to charge my card for services rendered, account balances, no show and late cancelation fees

Name on card: _____ Expiration Date: _____ Zip Code: _____

Credit card Number: _____ Security code: _____

Signature: _____