PARAMOUNT HEALTH DIRECTIONS
CINDY SOUSER FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing the best possible care. Our goal is that your or your child's treatment will be successful. Please read the following Financial Policy Statements and sign the statement below.

1) **Full payment is required at the time of service via check, credit card or cash.** Unless cancelled at least 24 hours in advance (the prior Friday for Monday appointments), our policy is to charge the full fee of the scheduled session for missed appointments. You will be automatically billed for the missed appointment.

2) We are not participating providers for any insurance plans. However, we will provide a receipt and additional documentation, if requested, to facilitate submitting claims. Please be aware that you are responsible for all charges for professional services rendered on behalf of the identified patient, including any charges not reimbursed by your insurance carrier. Note that some services may not be covered by your insurance, such as services provided outside of scheduled appointment times, including phone calls, letters, reports, faxes, copying of records, or consultations with other providers, schools, or insurance companies. By signing this form you also agree to let us release information to your insurance provider upon request for claim submission.

3) Charges for Cindy Souser are as follows:

Office:	**Home/School Visits:**
15 minutes - $55	15 minutes - $62
30 minutes - $110	30 minutes - $125
60 minutes - $215	60 minutes - $245
75 minutes - $270	75 minutes - $301.25
90 minutes - $325	90 minutes - $357.50

Urgent appointments are $250 per hour.

There is an annual 10% increase in fees as of January 1 of each year

Charges for **QbCheck** are billed at $189/per test plus an additional interpretation fee based on your provider's 30-minute appointment cost. **Other appointments including phone consults will be billed based on the applicable portion of the base fee.**

4) **Medical Records and Written Report Requests-** Written evaluation reports and request of medical records are not included in the cost of your session. A separate fee is charged for these requests. This fee will be assessed based on time spent for preparation and will be due in full upon release of these documents.

5) Legal work will be assessed a fee of 1.5 times the standard rate (this includes evaluations, preparation of documents and consultation with your legal counsel).

1. **Medicare:**

Dr. Stamatoiu and all providers at Paramount Health Directions have chosen to "Opt Out" of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign the federally mandated "Private Contract" in order to receive services at our clinic. All services must be paid

at the time of service and neither Dr. Stamatoiu nor the patient may file a claim to Medicare for reimbursement.

2. **Medicaid**:
We are not accepting any Medicaid patients. We will only accept "Private Pay" patients. We will not file any claims to Medicaid for reimbursement of your medical services now or at any time in the future.

3. **Champus/Tricare:**
We are not an active Champus/Tricare/Tricare for Life provider. We will NOT accept Champus/Tricare/Tricare for Life insurance; we will NOT file any claims to Champus/Tricare/Tricare for Life and we will NOT accept the Champus/Tricare/Tricare for Life fee schedule for reimbursement of our services.

A $25 rebilling fee will be assessed each month we need to send a statement with an outstanding balance unless payment arrangements have been made. We have the option of using legal means to secure payment for any accounts that are 90 days or more past due. This may involve hiring a collections agency or going through small claims court, which will require us to disclose otherwise confidential information. In most situations the only information we release is the patient's name, date of birth, social security number, nature of services provided and amount due. The responsible party will be responsible for all collection and/or legal fees.

I have read the Financial Policy. I understand and agree to the terms of the Financial Policy. I understand that I am responsible for services provided and for any collection or attorney fees, or court costs associated with use of outside agencies required for collection of fees.

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Printed Name of Patient

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Printed Name of Responsible Party

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Signature of Responsible Party Date