COLUMBIA UNIVERSITY DEPARTMENT OF PSYCHIATRY
PATIENT FINANCIAL AGREEMENT

I_____ (Patient Name) acknowledge the payment and insurance information set form below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the programs and physicians and other health care providers affiliated with the Columbia University, Department of Psychiatry, and Columbia physicians from other medical specialties asked to consult on my care by the psychiatric treatment team.

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I know that I may request and will receive a written fee schedule. Columbia may change its fees in the future. Insurance coverage may not pay for all my services. In some instances, payment will be solely my responsibility. I understand that:

    - Payment for regular outpatient service is due at the time of treatment. NOTE: I will be charged for outpatient appointments I do not keep, unless I cancel the appointment at least 24 hours in advance. I understand that I cannot submit bills for cancellations to my insurance company or managed care plan.
    - Payment for day treatment must have a credit card on file otherwise; a month in advance check is required based on my treatment plan.
    - Bills for inpatient treatment are sent after discharge. However, if I do not have insurance coverage for inpatient treatment I will have to pay in advance for the expected length of my stay in the hospital. Columbia will refund overpayments within 6-8 weeks.
    - Columbia offers a package of Enhanced Services for inpatient stays. This package is not covered by insurance. The price for these Enhanced Services is $_____ a day. If I choose to purchase this package, payment will be my responsibility. The Enhanced Services package consists of one or more professional services, per day, and may include: individual and/or family counseling with a clinical psychologist, individual substance abuse therapy and cognitive-behavioral therapy.

2. Insurance and Managed Care Plans: Columbia participates in a number of insurance and managed care plans. If Columbia participates in my plan, I agree to pay all applicable charges, deductibles, co-payments, co-insurances. If Columbia does not participate in my insurance plan, Columbia may, at its discretion, accept assignment from my plan. If Columbia accepts such assignment, I agree to pay any charges, deductibles and co-payments required by my plan. If my insurance benefits run out, Columbia will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage.

3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care: I agree to allow my insurance plan or managed care plan to pay Columbia directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Columbia unless I have already paid the charges myself.

    I authorize Columbia to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Columbia to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

4. I have signed a HIPAA [patient privacy laws and regulations] acknowledgment with the Department.

5. I understand Columbia may release me as a patient if I do not adhere to this agreement. If this happens, Columbia will assist me in making alternative arrangements for my treatment, if necessary.

6. Name of responsible party: _____Rel. to patient: _____

    Signature: _____Telephone: Work_____Home_____

    Address of responsible party: _____

    Date: _____ Witnessed by for Columbia: name: _____signature:_____

7. Credit Card Authorization for co-payments and fees by faculty physicians and providers of Columbia University

    Circle one: *Visa MasterCard Amex Discover* Account No: _____Exp._____

    Signature: _____Date:_____