Anna R. Flynn, M.D. Service Corporation

Anna Flynn, M.D.
Board Certified Adult, Child & Adolescent Psychiatrist

— FINANCIAL POLICY AND AGREEMENT —

Thank you for choosing us as your health care provider. We are committed to providing you with the best care possible. Please read the following information carefully and completely. Should you have any questions, please contact us immediately. Your clear understanding of our Financial Policy and Agreement is important to our professional relationship. You must sign and date this form prior to the beginning of care.

PAYMENT POLICY

Payment is expected at the time of service. You may pay with cash, check or Visa/Mastercard. If you become more than two visits or 60 days behind in payments, new sessions will be scheduled once the balance of your bill, which is your responsibility, is paid. If we can no longer serve you due to lack of payment, we will assist you in finding alternative care.

Whether you desire to file your insurance on your own or to not use insurance, payment must be made in full at the time of each visit. We will be happy to provide you with a "superbill" with the proper code numbers for diagnostic category and type of service provided. You may mail this to your insurance company or save it for your financial records. You will then be reimbursed directly by your insurance company per the terms of your policy.

Dr. Flynn does not participate in any insurance, Medicare, CHAMPUS or Medicaid plans. We do this in order to keep our costs reasonable and to allow us to spend time working on your treatment.

Insurance companies have different policies on out-of-network coverage services. Your degree of coverage is a matter between you and your insurance company and/or your employer. Reimbursement varies depending upon the level of benefits that you and your employer have chosen.

All charges are your responsibility from the date services are rendered.

FEES

Initial Assessment/Evaluation: $530.00 per 60-minute session

Medication Monitoring/Psychotherapy are pro-rated **in five-minute increments at Dr. Flynn's hourly rate of $530.00 per hour**. Travel time to and from the office is included in the charge.

Telephone calls and consultation with other professionals and/or review of patient records and report writing will be pro-rated **in five-minute increments at Dr. Flynn's hourly rate of $530.00 per hour.** These calls may or may not be covered by insurance.

No show fee/cancellation policy: **If you cancel in less than 24 hours of your appointment, or do not appear for your appointment, then the entire fee is charged for the missed session. This is further specified under #5 of the Office Policy form**.

Occasionally, appointments may be conducted in your home or office. In such cases travel time will be charged in addition to the appointment charge and at the same hourly rate.

RESPONSIBLE PARTY

If the patient is a minor (or is subject to guardianship under Court Order), both parents or guardian must (1) consent to treatment and (2) accept responsibility for payment for our services. In the case of divorced or separated parents – the parent(s) or guardian signing this form will be the party billed and agrees to be personally liable for any and all payments and balances outstanding. Reimbursement (from co-parents or other parties) to the Responsible Party signing this agreement must be handled directly by the Responsible Party; our office cannot bill such third parties.

For follow-up appointments, if you are a parent and are unable to accompany your child, who is a patient to the appointment, a credit card number is required to be on file. If there is a divorce agreement between parents detailing financial responsibility, then the parent that accompanies the patient is responsible for making payment at the time of service.

Thank you for understanding our Financial Policy and Agreement. If you have any questions, please do not hesitate to ask. Please sign below indicating that you have read and understand this policy and agree to abide by it.

Signature_____ **Date** _____
Of Patient, if over age 18

Signature_____ **Date** _____
Of Guardian and/or financially responsible person, if applicable

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