Anna R. Flynn, M.D.S.C
181 Waukegan Rd. Suite 105
Northfield, IL 60093

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. You must sign and date this form prior to the beginning of care.

Payment Policy

1). 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.

2). If an outstanding balance remains for a period of 60 days or more, Dr. Flynn may use an attorney or professional collection agency to retrieve the unpaid balance. You are responsible for any collection fees or court costs incurred.

3). 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 may then be reimbursed directly by your insurance company per the terms of your policy.

4). Dr. Flynn is not an insurance provider on any private insurance plans. She is also not a Medicare, MediCal, Champus, or Medicaid provider. If you wish to submit your claim to your insurance company, she will gladly provide a receipt for you to submit to your insurance company. Patients are responsible for all fees, and reimbursement, if any, shall be handled between you and your insurance company.

Accordingly, you are responsible for submitting any claims or receipts to your insurance company, resolving any disagreements over claims, and/or negotiating settlements directly with your insurance company. Because Dr. Flynn is not a Medicare or Medicaid provider, it is understood that you will not submit claims to Medicare or Medicaid for any services rendered by Dr. Flynn.

Dr. Flynn cannot accept responsibility for submitting or negotiating claims with your insurance companies, Medicare/MediCal, Medicaid or other parties. Any other financial arrangement must be made prior to Dr. Flynn scheduling an initial intake/consultation appointment.

5). All charges are your responsibility, on the date services are rendered.

Telephone: (847) 212-1909 Fax: (312) 275-7884

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FEES

Initial Assessment/Evaluation: $650.00 per 60-minute session

Medication/Monitoring/Psychotherapy: are pro-rated in five-minute increments **at Dr. Flynn's hourly rate of $650.00 per hour.** Travel time to Dr. Flynn's office will be similarly charged during days and times outside of Dr. Flynn's regular office days, office hours, and availability.

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 $650.00 per hour**. These calls may or may not be covered by insurance.

No show fee/cancellation policy: the fee for the missed session is charged for cancellations with less than 24 hours notice. Unless you designate otherwise, any late cancellations, no show fees, and additional service charges, will be directly charged to the credit card that Dr. Flynn has on file. Please refer to The Office & Practice Agreement document for included, but not limited to, examples of charged services rendered during the treatment process.

Late cancellations and no shows for initial evaluation will require a full deposit before rescheduling and full payment for missed appointment.

NSF returned check: $60.00 fee.

RESPONSIBLE PARTY

If the patient is a minor (or is subject to guardianship under Court Order), a parent or guardian must (1) consent to treatment and (2) accept responsibility for payment for our services. In the case of divorce or separated parents--other arrangements (including Court Orders and Decrees) nevertheless--the parent 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.

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

Print Name of Signer_____ Date_____

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