Welcome to Northern Psychiatric Associates

Thank you for choosing Northern Psychiatric Associates for your mental health needs. We are committed to providing you with the best possible care. Since payment of your bill is part of your treatment, we want to be sure that our financial policies are clearly understood before we begin treatment. We hope these guidelines will help you when addressing your questions and needs with our office.

APPOINTMENTS

If you are unable to come to an appointment, please call at least 24-hours in advance to cancel or reschedule your appointment or you will be subject to a $25 no-show fee. It is our policy that if you are a no-show for two appointments you will be charged with a $25 fee. If you have a third no-show, we will charge you $25 and we will discontinue services at our clinic and we will refer you elsewhere for psychiatric care.

INSURANCE/BILLING INFORMATION

Payment of your account is your responsibility regardless of your insurance coverage. Your insurance is a contract between yourself and the insurance carrier; we are not a party to that contract.

Our office has provider contracts with Medicare, Medical Assistance (including Minnesota Health Care and BluePlus/South Country Health Alliance), Blue Cross Blue Shield, Medica, BHP (Preferred One and UCare), Health Partners and Humana. We will file all insurance claims as a courtesy for you, including those claims where there is no provider contract. Please notify us of any changes in your insurance to avoid being billed incorrectly and/or delays in processing your claim(s). All insurance co-payments are due at the time of service.

You will receive a monthly statement from our clinic for the remaining balance after your insurance pays the claim. Payment will be expected within 30 days of receipt, unless other payment arrangements have been made. If you are unable to meet your financial obligations, you will need to initiate an alternative arrangement by contacting our business office.

PRESCRIPTION REFILLS

It is important for you to anticipate your medicine needs so you can discuss them during your office visit.
If you do not have a scheduled appointment and need medication, please call your pharmacist for **all** prescription refill requests at least **seven business days** in advance of your prescription refill need. Your pharmacist will call our office to obtain physician approval.

Certain medications can only be filled with the original, written prescription. You may call ahead to request a written prescription. You can either pick up the written prescription during regular office hours or NPA will mail it to you or your pharmacy.

I have read, understand, and agree to the above policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I understand that it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf. I understand that if I fail to attend my appointment, I am subject to a $25 no-show fee. I understand that it is my responsibility to contact my pharmacy for all prescription refill requests.

Signed:____

IF YOU ARE IN NEED OF EMERGENCY CARE, PLEASE CALL:

- The Crisis Line at (218) 828.HELP (4351)
- The Grace Unit at St Joseph's Medical Center at (218) 828.7437
- 911 or the nearest emergency room

PATIENT REGISTRATION AND RELEASE OF INFORMATION

Patient's Name: ____

Date of Birth: ______________________ Social Security Number: ______________________

Patient's Address: ____

City: ______________________ State: __________ Zip: ______________

Telephone: ______________________ Sex: __________ Marital Status: ______________

Race: ______________ Ethnicity:______________ Language: ______________

Occupation: ______________ Employer: ______________ Work#: ______________

Person Responsible for the Account: ______________ Relationship to Patient: ______________

Date of Birth: ______________ Work #______________ Employer: ______________

Person to Notify in case of Emergency: ______________________________

Relationship to Patient: ______________________ Telephone: ______________________

PLEASE FILL OUT THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18:

Mother/Guardian: ______________ Work #: ______________ Employer: ______________

Home Address: ______________________ City, State, Zip: ______________________

Father/Guardian: ______________ Work #: ______________ Employer: ______________

Home Address: ______________________ City, State, Zip:______________________

INSURANCE INFORMATION

Name of Insurance: ______________________ Insured Name: ______________________

Insured Date of Birth: ______________________ Relationship to Patient: ______________________

Insured SS#: ______________ Group #: ______________ ID#: ______________

MEDICAL HISTORY:

____

____

____

CURRENT PRESCRIPTION MEDICATIONS:

____

____

PREVIOUS PSYCHIATRIC TREATMENT?: ◻ YES ◻ NO

If yes, when?: ____

With whom?: ____

Medication, if any: ____

____

ALLERGIES:

____

____

____

HABITS: _____ Smoke Tobacco _____ Smoke Other _____Alcohol _____Drug Use _____ Other

RECORDS RELEASE: I hereby authorize the release of any information including medical and billing information, by Northern Psychiatric Associates (NPA) to any referring doctor, referring psychologist, insurance company, clinic selected collection agency or as directed on behalf of myself and/or dependents.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of Medical Benefits directly to NPA for services rendered to myself and/or dependents. I understand that I am responsible for my medical bills including those of my spouse and minor children, regardless of the extent of my insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION: I give consent to NPA to release to any third-party payor responsible for paying benefits on my behalf (including Medicare, Medicaid/Medical Assistance, my private insurer or any other governmental or private payor) any information needed to determine those benefits. I authorize release of my billing information to the clinic selected collection agency. I understand that I have a right to revoke this consent through written notification to NPA.

Date: _________________________________ Signed: ____
(Patient or Responsible Party)

Witness: ____

Northern Psychiatric Associates
7115 Forthun Road, Suite 105
Baxter, MN 56425
218-454-0090

I hereby acknowledge that I have received a copy of Northern Psychiatric Associates Notice of Privacy Practices.

____
Signature

____
Date