137 CRYSTAL BEACH DR STE. 137-C
DESTIN, FL 32541
INFO@THECRANECENTER.NET
WWW.THECRANECENTER.NET
P: (850) 226-7100
F: (850) 226-7157

Financial Policy

Please carefully read this policy and resolve any questions before signing agreement.

Payment is Due At The Time Of Service:

With the exception of deposits and non-standard services, all payments are due at the time of service. For your convenience and in order to avoid extra billing costs, we ask that you provide a credit/debit card to be kept on the file with our office. We will charge any applicable co-pay, deductible, co-insurance payments, telephone consultations fees and penalties (no-show/late cancellation charges) to the card on file.

If you are unable to keep a card on file we may request that payments be made in cash prior to appointments.

Insurance/Non-Insured Standard Service Fees

Please be aware that all providers at our office are considered out of network with all insurance companies. If you wish to file an out of network claim with your insurance, you will be responsible for submitting your own claims.

Out of Network: Primary insurance in which we do not participate will not be billed. The client will be responsible for paying the provider's fee at the time of service. The client is responsible for all out of network claims. Assignment will be made to the client so that insurance payments can be made directly to the client. *(Please be aware that if your insurance does not cover the full provider fee or if you are denied payment by your insurance, you will not be reimbursed for the difference by the provider.)*

Uninsured: If you are not a member of any insurance program a standard fee for service will apply. Payment will be due at the time of service. Acceptable forms of payment are listed above. Please direct any questions about these fees to the office staff.

Suboxone Treatments: Please see the separate Suboxone Agreement for fees associated with this service.

OFFICE USE ONLY Initial Date

INITIAL:_______ ___________/_________

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Other Charges:

Missed Appointments/Late Cancellations: There is a fee for missed appointments and cancellations with notification of less than 24 business hours. You will be responsible for the full cost of the visit. It will not be filed with your insurance since they do not cover these charges. As a courtesy, our staff will do their best to make appointment reminder calls. Missing/not receiving reminder calls does not relieve your responsibility for missed appointment charges as many circumstances arise beyond our control.

Previous Balances: Any outstanding balance owed on your account will be due prior to your next visit unless other arrangements have been made.

Returned Checks: Returned checks are subject to a $35.00 service fee and may increase based on banking fees for returned checks.

Collections: In the event that this office is unable to collect you payment a collections agency will be employed to clear the balance and any associated fees.

Credits: If there is a credit on your account balance then you may choose to have a refund issued or apply the credit to future appointments.

I have read and understand the financial policy outlined above. By signing below, I agree to be bound by these terms.

______________________________ Signature of Patient or Responsible Party

______________ Date

______________________________ Print Name of Patient (& Response Party if Applicable)

______________________________ Address of Patient Zip Code

(   ) ______________ Preferred Phone Number

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APPLICATION FOR SERVICES: ERIC GOLDBERG, D.O

Name: ______________________________ Date of Birth: ____________

Parent or Guardian if applicable: ______________________________

Address: ______________________________ Age: ____________

______________________________ SSN: ____________

______________ Zip: ______________ Sex:(Circle One) M F

(C) Phone:(____)________Ok to Call?_____ (W) Phone:(____) _______ Ok to Call?______

Email: ______________________ Ok to email appointment reminders? ____________

Martial Status: Married Single Divorced Separated Other

Employment: ______________ Position: ____________ Full Time? Part Time?

Emergency Contact: ____________ Relation: __________ Phone:(____) ________

Primary Physician: ____________ Phone:(____) ________ Ok to Call______

Previous Psych. Care? ________ If so, whom?____________________ Ok to Call?______

Phone:(____) __________

Primary Insurance: ______________________ ID# ______________

Insured's Name:______________________ DOB: ____________

Secondary Insurance: ______________________ ID# ______________

Insured's Name: ______________________ DOB: ____________

Driver's License #:______________________

I hereby apply and consent to such psychological counseling, consultation, testing and/or other services that may be recommended. I also understand that my failure to comply with treatment recommendations may result in my being discharged from treatment. I understand these services are voluntary and I may withdraw from treatment at any time.

______________________ ______________________ ______________

Signature Witness Date

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Insurance Release

I authorize The Crane Center to release any medical information required by my insurance company, if such is requested and is needed to determine benefits payable. Verification of insurance benefits through the customer service number on the back of the insurance card is not a guarantee of coverage. Actual benefits are determined at the time claims are processed. It is understood that I am responsible for the portion of the payment, the account balance is solely my responsibility, and I agree to make payments in a timely manner and in accord the policies of this business.

Signature: ______________________________ **Date:** ____________________

Credit Card Information

Effective December 19, 2016, patients paying by methods other than cash or money order will be requested to have on file, viable credit card information. As long as payments and balances are kept up to date, the credit card will not be charged. Balances are due at the time of service (including no shows and late cancellations) and if not paid, the balance will be charged in full to the credit card the day of the appointment. All returned checks will be immediately charged to the credit card, plus a $35.00 returned check fee.

Your credit card information is kept confidential and secure.

I/ we the undersigned authorize and request The Crane Center (Sand Dollar Psychiatric Services) to charge my credit/debit card listed below for balances due for services rendered. This authorization relates to all payments not covered by my insurance company for services provided to me by (The Crane Center/Sand Dollar Psychiatric Services). This authorization will remain in effect until I/(we) cancel this authorization. To cancel, I/(we) must give a 60 day notification to (The Crane Center/Sand Dollar Psychiatric Services) in writing and the account must be in good standing.

PLEASE CIRCLE: VISA MASTERCARD DISCOVER AMEX

Cardholder Name: ______________________________

Credit Card Number: ______________________________ Exp Date:_____/______

Address: ______________________ Zip Code: __________ CVC Code: ___________

I further certify that I have read and agreed to the above disclosures, and agree to abide to the conditions set forth therein. If you are unable or uncomfortable providing us with a credit card, we will kindly request that fees to be paid in the form of cash or money order at the time of service. We will not be able to see you without full payment.

Signature: ______________________ Printed Name: ______________________

Witness: ______________________ Date: ______________________

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YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your Protected Health Information, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain, very limited, circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies.
Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of your medical information for purposes other than treatment, payment, or health operation.
Request Confidential Communications: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, Work-related injury, and OSHA compliance.
Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location (for example, at work, or by U.S Mall). We will grant locations if you fail to respond to any communication from us that requires a response.
A Paper Copy of This Notice: You may ask us to give a copy of this notice.
If you have any questions about this Notice, please contact our Privacy Officer at **(850) 226-7100.**

We reserve the right to change this notice and to make the new provisions effective for Protected Health Information we maintain from the first date of your health record. The current notice will be posted and include this effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at (850) 226-7100. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use or disclose medical information about you, in writing, at anytime. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our record of the care that we provided to you.

Acknowledgement of Receipt of Notice of Privacy Practices, Office of The Crane Center.

By singing this document. I acknowledge that I have read a copy of this office's Notice of Privacy Practices.

____

Print Name **Signature** **Date**

Office Use Only:

Date of Acknowledgement received: ______________________ By: ______________________

OR Reason Acknowledgement was not obtained: ______________________________

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