MOUNTAIN VIEW PSYCHIATRY, LLC

Kevin N. Batterbee, D.O.
Trudy Wilson, MS, LPC

13550 Northgate Estates Drive
Suite #100
Colorado Springs, Colorado 80921
Phone: (719) 375-1491
Fax: (719) 445-0082

****THIS FORM MUST BE FILLED OUT COMPLETELY IN ORDER TO FILE INSURANCE****

Name:____ Date of Birth:____________________
Sex: M___F___ Social Security #__________________________ Marital Status:____________________
Address____
Street City State Zip

Relationship to responsible party (circle one): self / spouse / child / other
Home phone #:____________________ Work phone #:________________ Cell #:________________
Who referred you to Mountain View Psychiatry? __________________________________

<u>Responsible Party Information – Parent or Guardian if Patient is a Child</u>
Name:____Relationship to Patient:____________
Address:____
Street City State Zip
Employer and Employer's Address:____
Home phone #:___________________________________ Work phone #:_______________________

<u>Insurance Information</u>
Primary Insurance Name:____
Name of Primary Insured:________________________________
ID#_____________________DOB:_______Social Security #__________________________________
Claims Address:____
Street City State Zip
Phone #:_______________________________ Group or Policy #:____________________________
Secondary Insurance Name:____
Name of Insured:_____________________ Insured SS# or ID#________________________________
Claims Address:____

Phone #:____Group or Policy #:________________________________

Patient Information

Authorization: Payment is expected at the time of service. The above information is warranted to be true. I agree to be responsible for the charges incurred. If insurance is available, I authorize release of information for the purpose of filing claims, and also authorize payments of benefits directly to Dr. Kevin Batterbee/Mountain View Psychiatry, LLC/Kevin N. Batterbee, D.O., LLC.

Cancellation of appointments must be made 24 hours in advance to avoid a $50 failed appointment charge. **This fee is due prior to the next appointment.**

Signature:____
Date:_________________________________
Relationship to patient if not signed by patient:____

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FINANCIAL POLICY AND PATIENT RESPONSIBILITIES

1. Co-pays are due at the time of your appointment. If you are not able to pay your required co-pay, please reschedule your appointment for another time. Please do not ask us to make an exception to this policy. ____________ **initial**
2. You are responsible for any payments including deductibles. We reserve the right to suspend scheduling appointments for non-payment. **NO FURTHER SERVICES WILL BE PROVIDED UNTIL YOUR ACCOUNT IS UP-TO-DATE.** ____________**initial**
3. Initial visits with Dr. Batterbee are 45-60 minute appointments and follow-up visits are 20-30 minute appointments. If you extend beyond this time, your insurance will be billed for an extended appointment and you may be responsible for extra deductibles or coinsurance. Visits with Trudy Wilson, MS, LPC are 60-75 initially and 45-60 minutes each follow-up visit. _____________**initial**
4. Please be on time for your appointment. If you will be 15 or more minutes late, your appointment will be rescheduled and you will be charged a no-show fee. __________**initial**
5. **We strictly enforce a no-show policy**. A missed appointment fee of $50 will be charged for follow-up appointments and a fee of $100 for initial appointments will be charged if you do not attend your scheduled appointment or you cancel with less than 24 hours. This fee is your responsibility and will not be charged to your insurance. It will be due prior to scheduling your next appointment. Failure to pay this fee may result in suspension of appointment scheduling privileges. We will keep your credit card on file to charge this fee. _________**initial**
6. If a no show occurs on a Saturday, loss of privilege to schedule Saturday appointments will occur as they are in much higher demand. ___________**initial**
7. Three (3) missed appointments will result in discharge from our practice. If you have questions, please speak with your provider. ______________**initial**
8. Accounts carrying balances that are the patient's responsibility (co-pays, deductibles, or coinsurance) that are more than 30 (thirty) days past due will be sent to collections. A 5% interest rate on accounts that are more than 30 days past due will be charged. _____________**initial**

9. Referrals and prior authorizations for services received are the responsibility of the patient (or patient's guardian if patient is a minor). Services that are not covered because of failure to obtain referral or prior authorization are the patient's responsibility. ____________**initial**
10. Fee-for-service, cash, or uninsured patients will be required to pay the entire fee prior to seeing the provider. **______________initial**
11. If patient is a minor, patient must be present at every appointment in order to bill your insurance. If you wish to schedule an appointment without the patient present, the out-of-pocket fee will be $125 per half an hour. **____________initial**
12. We require a notice of 7 business days for any refill requests. **___________initial**
13. If you require a provider to complete disability paperwork, you will be required to schedule a separate appointment or will be charged an out-of-pocket rate of $250 which is due prior to the receipt of the paperwork. **___________initial**

_______(Initial) I WISH TO RECEIVE A COPY OF THIS FINANCIAL POLICY

or

________(Initial) A COPY OF THE FINANCIAL POLICY WAS OFFERED AND I DECLINE AT THIS TIME

I, the undersigned, have received/declined (please circle one) a copy of the Financial Policy of Mountain View Psychiatry, LLC and understand that I am responsible for following the policy guidelines. I also understand that failure of payment as outlined in the policy may suspend my ability to schedule appointments with my provider until payment arrangements have been made.

Patient/Responsible Party Signature:________________________________
Date:________________________________

PLEASE KEEP THIS PORTION FOR YOUR RECORDS

MOUNTAIN VIEW PSYCHIATRY, LLC
13550 NORTHGATE ESTATES DRIVE, SUITE 100
COLORADO SPRINGS, CO 80921

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to our practice. Mountain View Psychiatry, LLC will maintain the privacy of your health information and we will not disclose your information to others unless instructed by you, the patient, to do so, or unless the law authorizes or requires our practice to do so.

A new federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As a part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice, please contact Dr. Kevin Batterbee at (719) 375-1491