VIRGINIA
INTEGRATIVE
PSYCHIATRY, PC

Sudhir Nagaraja, DO MS

Board Certified Psychiatrist
Board Certified Integrative Medicine

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____DOB: _____

Dr. Nagaraja appreciates the confidence you have shown in choosing him to provide for your mental health needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Dr. Nagaraja, for providing psychiatric services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Dr. Nagaraja, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ **Date** _____

Non-Payment Policy

Dr. Nagaraja reserves the right to send any bill that is more than 90 days delinquent to a collection agency. In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's collection agency for collection. The collection agency will act as the provider's "Business Associate" in accordance with Dr. Nagaraja's privacy practices (notice of privacy practices is available at **www.drnagaraja.com**). The undersigned will be responsible for the full bill plus any charges made by the collection agency.

Patient/Guarantor Signature _____ **Date** _____