P.B.S. MENTAL HEALTH ASSOCIATES, P.C.
901 East Brady St., Suite 103
Butler, PA 16001
Phone: 724-282-1627 Fax: 724-282-4810

POLICIES
(effective April 2023)

PAYMENT - We accept cash, check, Visa, Mastercard and Discover.
Your CO-PAYMENT, deductible amount and coinsurance amounts are due at time of service and are a part of your contract between you and your insurance company and cannot be written off or discounted for any reason by our office.

SELF PAY
If you do not have insurance, payment in full is due at time of service.

RETURNED CHECKS
There will be a $25.00 fee for all returned checks, this fee and the amount of check must be paid with cash or credit card. Multiple check returns will result in cash or credit payment only and may be subject to filing with the local magistrate.

MEDICAL ASSISTANCE We DO NOT participate in the insurance and are not taking new patients that have this insurance as primary or secondary.

If you DO NOT have any form of Medical Assistance, Gateway, UPMC for YOU, Dual plans, etc. please initial here _____

FILING YOU INSURANCE CLAIMS – IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS!
Please remember that your insurance policy is a contract between you and your insurance company. We will as a courtesy bill your insurance to help you receive the maximum allowable benefit under your policy. Any unpaid balances are your responsibility. If we are not in network with your insurance payment is due in full at time of service and an itemized receipt will be given to you for self-reimbursement.

ADMINISTRATION FEES
A $40 fee is billed for any forms or letters done and sent to other providers, attorneys, employers and or insurance companies. This fee is due prior to information being sent. If not paid, information will not be sent.

COLLECTION POLICY – refund policy
Our office attempts to collect any outstanding balance using monthly statements AND by asking for payment upon check in. Payment on your account is due immediately upon receipt of statement. If you are experiencing financial difficulty, please notify our billing department. Every possible attempt will be done by our office to collect on your account prior to taking

outside collection agency action. If your account is sent to collections, your FULL AMOUNT DUE will need paid IN FULL prior to being able to reschedule with anyone in our practice. No refund under $1.00 will be issued by us or expected to be made to us.

MISSED APPOINTMENTS – LATE CANCELLATIONS

We require 24 hour notice for a cancellation of an appointment. If you do not call within this time frame OR no show to an appointment a $75.00 fee will be added to your account.

EMERGENCY EVENT

In the event of an emergency closing, all phones will have a prerecorded message with instructions. You will be contacted by a staff member regarding closure and/or rescheduling within 24 hours. If you are in need of immediate assistance, please report to the nearest emergency room.

AFTER HOURS

If you are experiencing a true medical emergency go to the nearest ER. Otherwise call the office at 724-282-1627 which is answered by an answering service and leave a message. If we have called your home using a different number DO NOT call the number, use 724-282-1627.

MEDICATION REFILLS

We need a 5 day notice to process medication refills. If it has been more than 6 months since you have been seen, you will be asked to schedule an appointment before a refill will be granted. All prescription requests must be called Monday – Thursday. No refills will be done on Friday.

MEDICARE PARTICIPTANTS

I REQUEST PAYMENT OF AUTHORIZED Medicare benefits to be made on my behalf to PBS for any services furnished to me. I authorize any holder of medical information about me to be released to the health Care Administration and its agents and any information needed to determine these benefits or the benefits payable for related services.

***Your signature on this form authorized PBS Mental Health Associates, PC (PBS) to release to your insurance company, information for billing purposes and direct payment to PBS. It also authorizes us to release information concerning medical care relating to mental health, medications, treatment planning and information related to utilization and quality assurance reviews to your insurance company should they require it. You also agree to endorse over to PBS any checks paid to you by your insurance company that were for services rendered here in our office. It is insurance fraud to cash these checks and not turn the monies over to us. Signature below also acknowledges I have read all policies above and agree to all terms.

Patient Name (printed) _____

SIGNATURE (Patient or Parent of Minor) _____Date _____