Better Mood Clinic
of South Georgia, LLC
2935 N. Ashley, Bldg F
Valdosta, GA 31602
Ph (229) 333-2273; Fax (229) 506-5403

Patient Financial Agreement

Thank you for choosing the Better Mood Clinic of South Georgia as your mental health provider! Our goal is to provide you with the services you need to feel better and become healthier and happier. An important aspect of optimal patient care is to have an agreement regarding your financial responsibility with us to avoid any misunderstandings and ensure timely payment for the services you received.

Better Mood Clinic of South Georgia requires that all patients, or their legal guardian, sign the Consent to Treatment and Financial Agreement prior to services being rendered. The Consent to Treatment authorizes Better Mood Clinic of South Georgia to render services to the specified patient(s). The Patient Financial Agreement advises patients of their complete financial responsibility for all services rendered.

It is our expectation that you will **keep your account current.** If there are problems that interfere with you keeping your account current, please ask to speak to our account's manager as soon as possible. Please note: **All** fees are due at the time of your service.

Initials: _____

Insurance:

This office files insurance claims at no additional charge to the patient/guardian. **However,** insurance information must be provided and verified before an appointment can be scheduled.

By signing this agreement, I allow Better Mood Clinic of South Georgia to bill my insurance on my behalf.

NEW CARD ON FILE FEATURE

As with many medical/dental, car rentals and hotels, the first thing you are asked for is a credit card, which is scanned and later used to pay your bill. This is an advantage for both you and the company, as it makes the checkout process easier, faster, and more efficient.

We have now implemented this policy at the Better Mood Clinic of South Georgia. Thus, you will be asked for a credit card at your first check in, we will scan the card in our system, and the information will be held securely.

Should your account collect a balance, you will be sent two statements. The second statement will contain a letter advising you that, should you not contact our office or remit payment within 30 days, we will charge the balance to the card on file.

Initials: _____

Forms of Payment Accepted:

Check * Cash * Money Order * HSA * Visa * Master Card * American Express * Discover

You will be asked to pay for the cost of any returned checks and all additional business costs related to the outcome of your financial situation. Minimally, these fees are $35. If your check is returned, you will not be able to write checks to this clinic until you can verify the availability of funds. If your card is declined, you will be asked for another form of payment. Treatment will resume when your account is current with no unpaid fee.

Be advised that all Credit/Debit Card transactions will incur a convenience fee of $2.50.

Initials: _____

Late Arrivals, Late Cancelations, & No Shows:

Late Arrivals – Patients arriving more than 15 mins late for their appointment will have a shortened session or be asked to reschedule. If rescheduled, you may be charged a no-show fee. We understand situations occur, so be respectful and advise us when running late.

Late Cancelations – Any appointment canceled less than 24 hours before their appointment time will be charged a fee based on the appointment type.

No Shows – Any time a patient does not show for an appointment they will automatically be charged a corresponding fee. That patient will not be able to schedule another appointment until the fee has been paid.

A "DNS" or Missed appointments are not only a loss of revenue but it also denies others from receiving treatment.

Initials: _____

Fees for Services:

Service Type	Therapist	Psychologist
Initial Visit	$185.00	$220.00
Follow Up Visit	$150.00	$170.00
Group Therapy	$75.00	
Psych Testing		$250.00 per session

Late Cancelation/No Show Fees

	Therapist	Psychologist
Follow Up Visit	$60.00 per hour	$80.00 per hour
Psych Testing		TBD

Initials: _____

Preferred Mailing Method to Receive Your Statement:

____ Mail
Address: _____

_____

____ Email
Email Address: _____

Initials: _____

By signing below, I acknowledge that I have **read, understand and agree** to the Patient Financial Agreement. I acknowledge that a record of this agreement can be emailed or printed out for me, if requested, for my records.

_____
Patient Name

_____ _____
Signature (If patient is a minor, must be signed by legal guardian) Date

BMC Staff Member Date