Bianca M. Kazoun LLC

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Office Policy

Please familiarize yourself with our office policies. If you have any questions, please call our office or your doctor.

Insurance

1. Patients are responsible for being aware of current insurance coverage. This includes the details of:
• Out of network benefits
• Deductible and/or "out-of-pocket"
• Need for pre-certification
• Current coverage and co-payment
• Maximum annual visits
• Current visits remaining
• Any changes in coverage
2. If you have exceeded your benefits covered you are responsible for the full payment for any uncovered sessions.
3. Your mental health coverage may be "carved out" to other managed care companies. We are considered out-of-network with those companies.
4. Please note that your insurance may place limits on the number of visits allowed per calendar year. This may not be sufficient to cover the clinically appropriate level of care determined by your provider.

3. Please inform your physician about needed refills at least 3 business days before your medication runs out. Set aside an emergency reserve of 3 to 5 days of each prescription .

Cancellations

1. Because your appointment time has been reserved for you, you will be charged for cancellations with less than 24 hours (one business day) notice. For example, if your appointment is scheduled on a Monday or following a long weekend, please call on the preceding Friday.
2. Charges for missed appointments are not covered by your insurance and are due and payable prior to any further appointments. Please note that such charges include the amount normally covered by the insurance company in addition to the copay amount.

Telephone Calls

1. Please leave your full name and phone number with your message. Please leave the best time of day to call.

Payment

1. Payment is expected at the time of appointment. We accept cash, checks, Visa or Mastercard.
2. Requests for written reports or records may incur additional charges.
3. There is a $50 charge for returned checks.

Patient name:

Birth date:

Signature:

Date:

Relationship to patient (if signed by authorized representative) _ parent _ legal guardian _ other:

I have received a copy of the office policy of Bianca M. Kazoun LLC and agree to the terms within.