Sanctuary for Healing and Integration, PLLC (SHIN)
Child & Adolescent and Adult Psychiatry
860 East 4500 South, Suite 302
Salt Lake City, UT 84107

FINANCIAL AGREEMENT

THIS IS A LEGALLY BINDING CONTRACT BETWEEN YOU, THE PATIENT, AND CARMELA J. JAVELLANA, M.D. & ASSOCIATES (dba SHIN):

1. **SELF-PAYMENT:** If you do not have insurance, payment must be received in full prior to services rendered. Any credit balances after charges are posted will be refunded to you within 30 days. Failure to pay or failure to cooperate with the billing process will result in suspension of care and discharge to your primary care physician.
2. **INSURANCE:** When giving your personal insurance information and/or showing your insurance card, you are stating and giving personal guarantee that your currently have insurance coverage (with that insurance company) on that date of service, and that all of the insurance and demographic information you give is correct/accurate and complete. In the event your insurance policy is not currently active and we find you are not covered by insurance, you immediately become personally responsible, guaranteeing payment on all medical services provided plus any professional fees that might arise. If your insurance does not pay for accrued charges within 60 days of submission by our billing company, you agree to pay the full amount due SHIN upon written notification. It will then become your responsibility to collect any reimbursement from your carrier.
3. **FINANCE CHARGE:** You agree to pay 18% annual simple interest rate (1.5% per month) on any balance not paid 30 days or longer.
4. **COLLECTION EXPENSE:** If your patient responsibility is not paid within 90 days of notification, you agree to pay any and all collection costs, reasonable attorney's fees, and court costs with legal expenses required to collect outstanding balances.
5. **RETURNED CHECKS:** You agree to pay $30.00 for any returned check or unpaid checks from your bank. You agree to pay $100.00 penalty fee on any check you have written to SHIN but have placed a stop payment order after the check was written.
6. **NO SHOW FEE:** Payment is required for the full amount of a previously scheduled appointment missed without prior 24-hour notice.
7. **RELEASE OF INFORMATION:** You give consent to SHIN to disclose any part of your medical record to any person or third party payer liable to patient under contract to carry out treatment, payment or healthcare operations. You have the right to review the privacy notice, request restrictions or revoke the consent for Release of Information. Revoking the Release of Information does not affect the rest of this agreement. The remaining terms of this agreement remain in full force and effect.
8. **ASSIGNMENT OF BENEFITS:** The undersigned authorizes payment directly to SHIN of the benefits herein specified and otherwise payable to the insured for professional services rendered for this period of treatment.
9. **PREAUTHORIZATION OF MENTAL HEALTH AND MEDICAL SERVICES:** Insurance carriers have a variety of internal policies and may deny payment for services rendered. Pre-authorization of services is not a guarantee of payment from your insurance company. By signing below, you agree to take full responsibility for payment of our professional charges for services provided to you.

I ACKNOWLEDGE THAT I HAVE READ THIS AGREEMENT AND HAVE RECEIVED A COPY OF THIS NOTICE.

Signature: ______________________________ Printed Name: ________________________________

Witness: _______________________________ Date: _______________________________________