Financial & Cancellation Policy

Please review this policy before beginning services. Fees shown below may be completed or updated by the practice.

INSURANCE & PATIENT RESPONSIBILITY

If TrueNorth participates with your health plan, claims will be submitted according to applicable plan requirements. Insurance coverage is an agreement between you and your health plan. Verification of benefits is not a guarantee of coverage or payment. You are responsible for providing accurate and current insurance information and promptly notifying TrueNorth of changes.

You are responsible for amounts assigned to you by your health plan, including applicable copayments, coinsurance, deductibles, and non-covered services, subject to your plan terms and applicable law. Patient-responsibility amounts may be collected at the time of service or after the health plan processes the claim. If a claim is denied because information you provided was inaccurate or coverage was inactive, you may be responsible for the balance to the extent permitted by law and your plan.

SELF-PAY SERVICES & GOOD FAITH ESTIMATES

If you do not have insurance or choose not to use insurance for a service, you are responsible for the self-pay fee. Uninsured and self-pay patients have rights under the federal No Surprises Act, including the right to receive a Good Faith Estimate of expected charges when required by law. A Good Faith Estimate is not a bill and may change if your treatment needs change.

If the billed amount for a provider is at least $400 more than that provider's Good Faith Estimate, you may have the right to use the federal patient-provider dispute resolution process. Nothing in this policy waives rights available under federal or California law.

FEES

Initial psychiatric evaluation: _____ Follow-up / medication management: _____

ADHD evaluation/testing (if applicable): _____ Other self-pay service: _____

Insurance cost-sharing may differ from self-pay rates. Any service-specific fee schedule or Good Faith Estimate provided to you also applies.

PAYMENT & CARD ON FILE

Payment is due according to the amount and timing communicated by TrueNorth and your health plan. TrueNorth may require a valid payment method on file for patient-responsibility balances. Payment credentials should be stored through the practice's secure payment processor rather than in the clinical record. Charges to a stored payment method are governed by your separate Card-on-File & Payment Authorization.

If you believe a charge is incorrect, contact TrueNorth promptly so the account can be reviewed. Nothing in this policy prevents you from exercising lawful billing, insurance appeal, or payment-dispute rights.

CANCELLATIONS & MISSED APPOINTMENTS

Appointment time is reserved specifically for you. Please provide at least 24 hours' notice if you need to cancel or reschedule. A late cancellation or missed appointment may be subject to the fee below, except when waived by TrueNorth or when charging the fee would be inconsistent with applicable law, payer requirements, or your health plan contract.

Late cancellation / no-show fee: _____ Required notice: _____ hours

Insurance generally is not billed for a missed appointment. Repeated missed visits may affect the practice's ability to continue scheduling care.

LATE ARRIVAL

If you arrive or connect late, your appointment may need to be shortened or rescheduled if there is not enough time to provide safe and clinically appropriate care. A rescheduled visit may be treated as a late cancellation when the applicable notice was not provided, subject to the exceptions described above.

PRESCRIPTION REFILLS & ADMINISTRATIVE REQUESTS

Medication refills should be requested with sufficient time for clinical review. A refill is not guaranteed without an appropriate follow-up visit, required monitoring, or other information needed for safe prescribing. Controlled medications may be subject to additional clinical and regulatory requirements.

Requests for letters, forms, disability paperwork, record summaries, extensive prior authorizations, or other non-visit work may require additional time and, when permitted, may involve a separate fee disclosed before the service is performed.

Optional forms / administrative fee, if applicable: _____

OUTSTANDING BALANCES

TrueNorth will make reasonable efforts to communicate patient balances. You agree to keep your contact and billing information current. If a balance remains unpaid, non-urgent services or future scheduling may be limited or paused when legally and clinically appropriate. Any transition or termination of psychiatric care will be handled consistent with professional obligations, patient safety, payer requirements, and applicable law.

Accounts will not be handled in a manner that interferes with rights available during an applicable federal patient-provider billing dispute. Any collection activity, if used, will be conducted in accordance with applicable law.

REFUNDS & CREDITS

Overpayments or account credits will be reviewed and refunded or applied as appropriate based on the source of payment, insurance adjustments, applicable law, and practice policy. Insurance processing can change the amount ultimately owed.

CHANGES TO INSURANCE OR COVERAGE

You are responsible for notifying TrueNorth promptly if your insurance plan, member identification, eligibility, or coordination of benefits changes. If TrueNorth becomes out of network with your plan or your coverage changes, the practice will communicate available options when reasonably possible. Your financial responsibility will remain subject to applicable law and payer terms.

QUESTIONS ABOUT YOUR BILL

If you have questions about a charge, insurance processing, or your balance, please contact TrueNorth before assuming a bill is correct or incorrect. We will review the account and, when appropriate, correct billing errors or explain the balance.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have reviewed TrueNorth's Financial & Cancellation Policy and had an opportunity to ask questions. I understand my responsibility for applicable patient balances and the cancellation/no-show policy. I understand that this policy does not waive rights or protections available to me under my health plan or applicable federal or California law.

I understand that fee amounts may change prospectively. When required, TrueNorth will provide notice of updated fees or other financial terms before they apply.

Patient Name: _____ Date of Birth: _____

Patient / Legal Representative Signature: _____

Type full legal name as electronic signature if completing electronically.

Date: _____ Relationship / Legal Authority (if not patient): _____