EMORY UNIVERSITY SCHOOL OF MEDICINE

Child and Adolescent Mood Program

Department of Psychiatry and Behavioral Sciences
Emory University School of Medicine

SLIDING SCALE CLINIC

STATEMENT OF FINANCIAL RESPONSIBILITY

Patient Name: _____ **Date**: _____

Person Responsible for Bill: _____

This Statement of Financial Responsibility will provide you with information about billing and payment procedures for the Sliding Scale Clinic at Emory University School of Medicine's Child and Adolescent Mood Program (CAMP). It also serves as a contract between you and CAMP confirming that you agree to pay for all services received through the Sliding Scale Clinic. Completion of this Statement of Financial Responsibility is required for all patients seen through the Sliding Scale Clinic.

PAYMENT INFORMATION
The responsible party should make payments using cash or check. **We do not take credit cards for our Sliding Scale Clinic fees.** Checks must be made payable to the Child and Adolescent Mood Program.

DUE DATE
Payment is due at the time of service.

INVOICE INFORMATION
Financial invoices are mailed the first week of each month. These invoices are mailed to the Person Responsible for Bill as indicated on the pre-registration information sheet. Patients without a complete pre-registration information sheet will have invoices mailed to the permanent mailing address on file. You are responsible for all charges regardless of whether or not you receive an invoice in the mail.

INSURANCE PARTICIPATION
You may not bill any Sliding Scale charges to any insurance company, nor may you seek reimbursement from any insurance company for Sliding Scale payments made. You may not submit Sliding Scale payments towards any insurance deductible.

I have read and understood the above policy regarding my financial responsibility to the Child and Adolescent Mood Program for providing services through the Sliding Scale Clinic for the above named patient. I agree to pay CAMP, at the time of service, the full and entire amount of all charges incurred by the patient. I agree to not submit Sliding Scale charges or payments to an insurer and to not seek reimbursement from an insurer for Sliding Scale payments made.

Signature: _____ Date: _____
(Person Responsible for Bill)

Name (please print): _____

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SLIDING SCALE CLINIC:
MISSED APPOINTMENT CHARGES

Date: _____

I, _____, understand and agree that I will be billed the full appointment fee for any missed appointments or appointments cancelled within 24 business hours of my scheduled visit. I understand such charges are my responsibility, and that it is my responsibility to pay this fee within 30 days.

_____ _____

Signature of Patient Date

Child and Adolescent Mood Program
12 Executive Park Dr. NE, Suite 200
Atlanta, Georgia 30329

Tel 404.727.3443
Fax 404.727.3421

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