REQUEST FOR TREATMENT AND INSURANCE VERIFICATION

This is to certify that I, _____ authorize Ghazanfar Khan MD and or Hani Ahmad MD to file claims to my insurance company(s) for services rendered to me by Ghazanfar Khan MD and/or Hani Ahmad MD affiliates of Advanced Psychiatric Health Inc.. I certify that the information I have reported with regard to my insurance company is correct. I understand that I am responsible to notify Advanced Psychiatric Health Inc. if my insurance company changes, benefits are terminated or if the coverage I have reported is incorrect. I understand and agree that it is my responsibility to understand the benefits of my insurance plan and that failing to do so may result in lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payment in full for all services that I have received from Advanced Psychiatric Health Inc.

If a referral is required, I understand that it is MY responsibility to obtain all documentation required by any insurance carrier or reimbursing agent in order to determine payable benefits.

_____ Patient Initials

PAYMENT AT TIME SERVICES ARE RENDERED

I understand that payment of the Estimated Bill will be made at the times services are rendered. I understand that my Estimated Bill will be provided prior to leaving the office and will detail my expected out-of-pocket charges based on Advanced Psychiatric Health Inc.'s contractual fee schedule with my insurer and the details of my particular insurance plan. The Estimated Bill will detail all deductible, co-pay, and co-insurance expected to be owed by me to Advanced Psychiatric Health Inc.. It is anticipated that my Explanation of Benefits will detail these charges after submission of my claim. My estimated payment could potentially result in an under-payment or overpayment based on my insurance carrier's determination of the filed claim. If an under-payment occurs, I understand that I will be billed for the remainder owed. Advanced Psychiatric Health Inc. will issue a prompt refund for any overpayment that is made by me.

_____ Patient Initials

PATIENT ACKNOWLEDGEMENT OF NO SHOW POLICY

I understand that the practice requires notification of cancellation of any appointment at least 24 hours in advance. If I miss an appointment (No Show) or cancel an appointment less than 24 hours in advance, I will be responsible for a No Show Fee of $25.00 per occurrance. I also understand that it is the practice's policy to dismiss any patient who has three missed appointments.

_____Patient Initials

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices (HIPAA) and I have been provided the opportunity to review the document.

_____ Patient Initials

I have fully read and initialed the information in each section above, and with my signature below, agree to the terms and conditions listed in each section above.

_____ _____

Signature of Patient/Responsible Party Date

Relationship to Patient (if applicable):_____