

Synapse Association Inc.  
2043 Anderson Rd., Unit D  
Davis, CA 95616  
Phone (530) 918-4093  
Fax: (530) 924-4816  
[www.synapseassociation.com](http://www.synapseassociation.com)

## Patient Services Agreement

### Terms and Conditions

1. Payment for Services: It is understood and agreed that whether I am signing as an agent or a patient, I am required to pay in full for services rendered by this office, regardless of whether my insurer covers such expenses. I hereby individually obligate myself to pay the account of this office in full in accordance with its rates and charges. I understand that the designated billing company will mail two statements via USPS to the address I provided, regarding any balance owed.

Initial: \_\_\_\_\_

2. Assignment of Insurance Benefits: Whether signing as a patient or as an agent, I authorize direct payment of any insurance benefits otherwise payable to me for my treatment by this office and/or charges relating thereto. I also acknowledge and understand that I remain financially responsible for charges not covered by my insurance provider, for any reason. I acknowledge that insurers do not guarantee payment for rendered services (even when a preauthorization is obtained by the office), for amounts deemed patient responsibility, or for non covered services. In cases of patient responsibility (es, copayments, or co insurances) (Refer to page 6 for the office policies and payment details) deductible there will be a 60-day grace period to allow for receipt of payment from the insurer and thereafter I understand that I am solely responsible for the balance owed and will be billed accordingly. I understand that I will be expected to satisfy the balance immediately. Thereafter, I may be subjected to interest charges at the legal rate and treatment may be discontinued immediately.

Initial: \_\_\_\_\_

3. Managed Care Plan: It is my responsibility to know and understand my managed care plan. Generally, insurance plans require payment of deductibles and/or copayments. I understand that if Synapse Association contracts with my insurer, the office will only file patient insurance claims if I provide them with the proper information, along with a copy of my current insurance card and/or other sufficient proof of insurance. If I do not provide accurate or updated information about insurance plan(s), I run the risk of being responsible for the service cost. In the event that an insurer overpays, this office will refund the overpayments to me within a reasonable time after a written request. Otherwise, overpayments will be credited to my account for future services.

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4. Primary and Secondary Insurance: Please be advised that it is your responsibility to provide all accurate insurance information to the office. If you have more than one insurance, you must provide us with all the information or any updates as they may occur in the future. A delay or non disclosure may result in your being responsible for the entire balance of your account. If you have more than one insurance, you must tell us which is primary and which is secondary. You can not use your insurance out of the order determined by your insurance company's coordination of benefits policies. You are responsible to know what those policies are as there are too many specialized plans for us to know all of your benefits. If you have any questions about your policies we ask that you clarify them with your insurance prior to treatment in our office.

Initial: \_\_\_\_\_

5. Termination Policy: I understand that this office has the right to discontinue services at any time, without limitations, for any reason. Reasons may include: failure to attend a scheduled appointment, failure to reasonably communicate or cooperate with the treating physician and staff, and/or failure to comply with prescribed treatment requirements. Likewise, I am aware that my treatment is "at will" and I reserve the right to terminate or refuse treatment ( including medication) at any time. While undergoing any treatment, I agree to immediately inform Synapse Association or anything pertaining to or effecting my treatment. I commit to achieve my treatment goals by effectively communicating with this office. If there is a lapse of more than 3 months, other than circumstance, the clinician advises a longer period, a letter to schedule an appointment will be sent to me. If I fail to make an appointment within 15 days upon receipt of the letter it will be considered a noncompliance to the doctors' orders, and a second letter will be sent to me notifying me of my discharge from the office.

Initial: \_\_\_\_\_

6. Prescriptions: I understand that it is my responsibility to keep track of refills of my medications and that I need to contact my pharmacy and the office for refills. I acknowledge that this office requires a seven-day notice for refills for any controlled or pre-authorized medications. The process for refilling medications with this office shall proceed as follows; contact the pharmacy for refill, and place a call to the office. I understand it is my responsibility to pay for my medications and to obtain a list of medications covered through my insurance policy. I am aware that this office processes prior authorizations as a courtesy to the patients and that it is not a requirement for treatment, nor are there any rules/laws mandating the processing of the medication authorization requests. This office policy is 14 working days for the submission of medication authorizations, in the event there is a denial for an authorization, this

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office will not seek further actions. The office has discretion to retract this courtesy at any time for any reason without explanation. Requests for authorizations are done only for medications where the cost is more than \$50.00 for a 30 day supply. Synapse Association will give timely notification to patients when/if the processing of medication authorizations is no longer available as a courtesy. Any requests given prior to the date of retraction will still be honored and processed accordingly.

Initial: \_\_\_\_\_

6. Cancellation Policy: I understand that per policy at Synapse Association there is a penalty fee for missed appointments or for failing to give notification of cancellation at least 48 hours prior to my appointment. If I am more than 10 minutes late for my scheduled appointment I accept that my appointments can be canceled and will be rescheduled.

Initial: \_\_\_\_\_

7. Release of Information: I authorize and consent for this office to disclose necessary information, including portions of my patient/medical records, to any person or corporation that is/may be liable for any portion of my offices charges for services rendered to the extent necessary in order to determine liability for payment and to allow this office to obtain reimbursement this include, but is not limited to insurance companies, health care service plans, and/or workers compensation carriers.

Initial: \_\_\_\_\_

8. Informed Consent: I am aware that I have the right to know risks, benefits and treatment alternatives before consenting to any treatment except for simple/common procedures and in emergency situations. I also understand that I have the right to refuse treatment by withholding consent.

Initial: \_\_\_\_\_

9. Arbitration: I understand that any dispute as to medical malpractice, that is, as to whether any medical service rendered under this Patient Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, an not be a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. I understand this arbitration agreement applies to any legal claim or civil action in connection with these services including but not limited to a dispute as to medical malpractice against Synapse

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Association, Inc., or its employees, agents, or representatives or unless rescinded by my written notice within 30 days of signature. Arbitration will be in accordance with the current Medical Arbitration. Rules of the California Medical Association and the California Association of Hospitals and Health Services.

Initial: \_\_\_\_\_

10. Partial Invalidity: I understand and agree that if any provision of this agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

Initial: \_\_\_\_\_

11. Governing Law: I agree that this agreement will be governed by and construed in accordance with the laws of the State of California.

Initial: \_\_\_\_\_

12. I understand that the doctor cannot see me for an appointment if I am not physically in the state of California. I agree to be in a private, safe, confidential location for telemedicine appointments. I will provide my exact location while doing telemedicine appointments. I will not do sessions while driving a vehicle.

Initial: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date