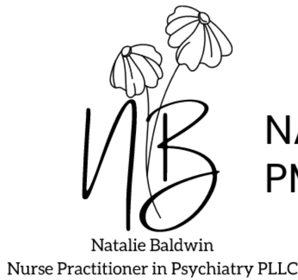

NATALIE BALDWIN
PMHNP-BC

P: 518-362-7818
F: 518-616-9511
A: 1 Pine West Plz Ste 110
Albany NY 12205

Patient Name: ________________________________ Date of Birth: ______________

Please read and sign below to show your understanding and agreement to the following contract terms:

Financial Policy
Payment is required at the time services are rendered. You will receive a text and email through which you may make a payment. Payments accepted are credit cards and cash. No personal checks will be accepted. All invoiced amounts shall be due and payable within thirty (30) days after receipt. To the extent permitted by law, your provider reserves the right to terminate all medical services to you if bills are not paid within 30 days of receipt.

Policy on Insurances
Please realize that your insurance is a contract between YOU and your INSURANCE COMPANY and you are ultimately responsible for payment. You are responsible for ensuring your visits to this practice are authorized by your primary care physician before your scheduled visit if prior authorization is required by insurance. You are responsible for any copays/co-insurance/ deductibles at the time of your visit. It is your responsibility to inform the office of all insurance coverage you may have and to verify coverage with your insurance company. If your insurance coverage is not active during the time of your visit you will be responsible for the full fee. It is your responsibility to inform the office of any changes to insurance prior to your scheduled visit. Further, you will be responsible for any medical services deemed “non-covered”, “covered terminated”, “pre-existing”, or denied by your insurance.

Medicaid/Medicare
Please note, this practice does not participate in Medicare or straight Medicaid. Some managed Medicaid insurance programs are accepted.

Non-participating insurance and Self-pay
This practice does not participate in all insurance companies or plans. Without qualifying insurance, you will be considered self-pay. You agree to assume full financial responsibility for all services rendered. An itemized bill can be provided for those seeking reimbursement from their insurance carriers. Self-pay rates are available upon request.

Fees related to Collection Efforts
If you or your insurance do not pay in a timely fashion, you agree to reimburse this practice the fees of any collection agency and expenses, including reasonable attorneys’ fees, incurred during collections.

By signing below, I am acknowledging that I have read and understand the terms set forth above.

______________________________ ______________________________ ____________
Patient or Parent/Guardian(if under 18) *Signature* Printed name Date

Relationship to patient