SSQ PSYCHIATRY LLC
PAYMENT AUTHORIZATION FORM

Payment Responsibility

I, the undersigned, agree to pay for all services furnished to me by SSQ Psychiatry LLC. I understand and acknowledge that the services provided by SSQ Psychiatry LLC are voluntary and constitute a private medical service, and are not covered by my insurance, government program benefits or other third-party payers. I also agree to pay or reimburse SSQ Psychiatry LLC, for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. I agree that any co-payment or payment is due at the time of service.

Payment Authorization for Lab Services

I, the undersigned, authorize SSQ Psychiatry LLC to send lab services to the appropriate laboratory for testing. I understand and acknowledge that the respective lab may directly bill my health plan, third-party payer or Medicare for such testing services rendered to me by or on behalf of this laboratory. I acknowledge that the laboratory is not obligated to submit claims to third party payers on my behalf unless required by law or by its contract with a particular third-party payer. I also authorize my health plan, third-party payer or Medicare to make payment directly to the respective laboratory for testing services rendered. I understand and agree that SSQ Psychiatry LLC is not responsible for the payment charged by the laboratory testing, or the laboratory's third-party payments or negotiating disputed settlements on my behalf. I understand and acknowledge that if I do not have a health plan, third-party payer, or Medicare/Medicaid to cover this laboratory test, then I am personally responsible for the payment of this laboratory testing expense.

_____ I acknowledge that I am covered by a certain health plan, third-party payer, or Medicare/Medicaid to pay for this laboratory test, and shall provide this information to the provider.

_____ I acknowledge that I am NOT covered by a certain health plan, third-party payer, or Medicare/Medicaid to pay for this laboratory test, or that I do not wish to send this laboratory test to such entity, and shall pay for the laboratory test at the time of the provider's services.

Amount of Payment for Services by Patient: ____________

Amount of Payment for Laboratory Testing by Patient: ____________

Name of Patient: ______________________________

Signature of Patient: ______________________________

Date: ______________________________

Signature of Parent or Legal Guardian:____________________________

Name of Parent or Legal Guardian:_______________________________