Stonebriar Psychiatric Services, P.A.

Payment of Services and Missed Appointment Agreement Form

Our services are provided by appointment only and when a patient schedules an appointment, time is reserved for that patient and not available to others. Missed appointments, as well as those cancelled with less than a **minimum** 24 *business* hours' notice (48 hour **minimum** on extended sessions and 1 full week **minimum** notice on intensives, which are appointments including over 120 minutes scheduled in one day) will be charged the fee for the visit. Business hours are when staff are in the office.

This same credit card will be used in the event of a phone session or other service whether patient is in the office or not (prescription refills, reports, forms, letters, phone calls, phone calls to outside therapists, etc), as well as to cover checks returned for nonsufficient funds (NSF), or an outstanding unpaid balance.

Patient Name: _____

The fee for the visit will be charged on the day of the missed appointment (or day of the late-cancel) to the following credit card:

____Visa ____MasterCard ____American Express _____Discover

Credit Card #: _____

Expiration Date: _____

Name as it appears on Card: _____

Security Code from back of card: _____

I, _____, cardholder for the credit card listed above, understand and agree that if I or my family member do not show up for a scheduled appointment or if I cancel a scheduled appointment with less than a minimum **24** *business* hours' notice (48 hour minimum *business* hours' notice extended sessions) **and 1 full week** minimum *business* hours' **notice on intensives, which are appointments including over 120 minutes scheduled in one day**), the above named credit card will be charged for the full amount of the reserved session. Additional fees as listed above will also be charged. If I have prepaid an appointment and the patient does not show or provide adequate notice, I understand and agree that **NO REFUND WILL BE ISSUED.**

Cardholder Signature _____ **Date** _____

Printed Name _____

Billing Address: _____

City: _____ Zip: _____ Day Phone_____

- ***To qualify for a timely cancellation on <u>individual</u> Monday appointments, the cancellation must be received by the corresponding time on the previous Thursday. Cancellations immediately preceding a holiday break must occur before the corresponding time on the last business day before the holiday. Voice mail and e-mail cancellations do not qualify as they can not be guaranteed as received.***

ADDITIONAL AUTHORIZATION

☐ Use this authorization to charge services for all my family member(s) who are also seen at the office. _____ (initial your approval)

Otherwise a separate form will be required for each individual.

☐ All Family Members _____ (initial your approval)