FAMILY PSYCHIATRIC ASSOCIATES

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SIGNATURE ON FILE – LIFETIME FORM AND PAYMENT AGREEMENT

By signing this document, I _____, have fully read and understand the financial policy of Family Psychiatric Associates, P.C. I agree to cooperate with the billing department of this practice to ensure payment for the services I receive. I further understand that I will be responsible for the cost(s) associated with the collection of my account if I default on this agreement.

The terms of this financial policy may be amended at any time without prior notification.

Please initial next to each item.

_____ 1. I authorize Family Psychiatric Associates, P.C. to charge my credit card on file for the balance of charges not paid by insurance within 90 days of the date of service.

_____ 2. I authorize Family Psychiatric Associates, P.C., to charge my credit card on file for private pay balances, deductibles and co-payments if I do not make payment on the date of service.

_____ 3. I authorize Family Psychiatric Associates, P.C. to charge my credit card on file a $15.00 fee for medications, which are required to be refilled between medication management appointments.

_____ 4. I authorize Family Psychiatric Associates, P.C. to charge my credit card on file for letters, reports, phone calls and record requests and any other fees that are incurred on behalf of my psychiatric treatment and care.

_____ 5. I authorize Family Psychiatric Associates, PC, to charge my credit card on file a $60.00 fee for a missed appointment that I failed to cancel without the proper 24-hour notice.

Patient Name: _____

Signature of Patient or Guardian of Minor: _____

Date: _____