WESTON
— PSYCHIATRIC —

Financial Agreement

Find Balance, Build Your Strengths, and Achieve Mental Well-Being.

Name:_____ DOB:_____

This form is an agreement between you and Weston Psychiatric. The use of the word "patient" below may refer to you, your child, or another person for whom you serve as a legal guardian.

Fees: Weston Psychiatric is committed to providing the best treatment for our patients and we charge what is usual and customary for our geographic area. The current fee schedule can be obtained by contacting Weston Psychiatric.

Cancellation/No-Show Policy: Cancellation of scheduled appointments is required at least 24 hours in advance. Failure to cancel within this timeframe prohibits this office from scheduling other patients in that time slot. Therefore, if a minimum of 24-hour notice is not received, you will be billed for 50% of the appointment fee. Chronic missed/late cancelled appointments shall result in being placed on 'same day' appointment scheduling.

Severe Weather Cancellations: In the event of a severe weather event, there will be no charge for late cancellations of appointments. Please notify our office immediately if you plan to miss a same day appointment due to a severe weather event so that your provider may be notified. Telehealth may be offered in its place.

Cash/Self-Pay: Weston Psychiatric is committed to helping meet your behavioral health needs by offering discounted pre-paid cash options and bundle pricing for services. It is understood that payment will be collected prior to the service and is non-refundable, including but not limited to unused sessions for bundled options.

Insurance Information: For your convenience, when receiving out of network services, upon your request, Weston Psychiatric will provide you with a Superbill to submit to your insurance carrier for reimbursement consideration. It is your responsibility to know the limits of your policy, your copay, and deductible obligations, your maximum benefits, and any managed care requirements. Please notify this office with any change in insurance coverage, or if there is any secondary insurance information.

Payments: All copayments are due at the time of service. Payment is required for all outpatient mental health visits, telemedicine appointments, and follow-up appointments before you are seen by the healthcare provider. We require a credit card to be kept on file. We reserve the right to charge this credit card to collect any outstanding charges for services and fees. If you have an outstanding balance with Weston Psychiatric, you may not be seen. Weston Psychiatric will charge a fee of $35 for returned checks.

Changes to the Financial Agreement: We reserve the right to change the Financial Agreement, including fees, at our sole discretion and from time to time without notice to you. If you do not agree to any amendments, you may stop services with Weston Psychiatric and terminate this agreement. Your continued use of Weston Psychiatric's services after you are notified of any change will constitute your agreement to the change.

I, the undersigned, have read the financial policies and agree to the terms.

_____ _____

Signature (First & Last Name) Printed (First & Last Name)

_____ _____

Name (if different than patient) Date (mm/dd/yyyy)