

**FAMILY  
PSYCHIATRY and  
PSYCHOLOGY  
ASSOCIATES, P.A.**

**FINANCIAL POLICY**

**APPOINTMENTS**

The keeping of regular appointments is the most effective means of successful therapy. As schedule permits, we will work out a most convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you. We will charge for telephone and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should your provider deem it appropriate. Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at the rate of the reserved session. You will be billed directly for this time.

**PAYMENT OF FEES**

Payment is to be made in full at the time of service. We accept cash, check, MasterCard/Visa, and Discover. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a \$25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

**CONSENT TO RELEASE OF INFORMATION**

Patient agrees that his individual provider may share information with other providers at Family Psychiatry and Psychology Associates, P.A. (FPPA) with regard to his/her case in order to better provide quality treatment. This information will be kept strictly confidential and remain in the confines of FPPA only.

**REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS**

Any reports, professional consultations, or clerical tasks involving time beyond that of the regular scheduled session will be a pro-rated charge for the professional or clerical time involved.

**READ CAREFULLY AND SIGN**

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

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Signature of Patient/Responsible Party

Date

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Signature of Office Staff or Doctor