

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.

The fee for the visit will be charged on the day of the missed appointment 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 on extended sessions **and 1 full week minimum notice on intensives, which are appointments including over 120 minutes scheduled in one day**) the *business hours' notice*, the above named credit card will be charged for the amount of the session.

Cardholder Signature _____ **Date** _____

Printed Name _____

Billing Address: _____

City: _____ Zip: _____ Day Phone _____

- ***To qualify for a timely cancellation on 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.***

OPTIONAL AUTHORIZATION (separate authorizations may be completed if desired)

I would like for this same credit card to be used in the event of a phone session or other requested service for which I am not in the office (prescription refills, reports, forms, letters, etc) _____
(Initial your approval)

Use this card to pre-pay my appointment: _____

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

All Family Members _____ (initial your approval)

Specific family member(s)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)