CHILD & ADULT PSYCHIATRISTS OF THE PENINSULA

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT - C

PAYMENTS

I am responsible for payment in full -- either upon receipt of each monthly statement or at the time of each session. Personal check, cash, MasterCard and VISA are accepted modes of payment. Defaulted accounts will be sent to collection. When a balance becomes 90 days past due, interest may be charged @ 10% per month.

CANCELLATIONS

I may be charged for missed or cancelled appointments, depending upon my doctor's cancellation policy. I understand that most insurance companies do not pay benefits for missed or cancelled sessions.

Please Note: You may need to contact your doctor a specified number of hours (usually 24 to 48 hours) in advance of the scheduled appointment time to avoid being charged for the missed appointment. Consult with your doctor to learn the specific time frame.

FINANCIAL RESPONSIBILITY

The person who signs this financial responsibility agreement is responsible for payment on my account. If I wish to designate someone other than myself as the person financially responsible for my account, that person must sign the financial responsibility agreement.

In the situation of divorced or separated parents of a child patient, one parent must be designated as the primary financially responsible parent who will make payments on the child's account, with any division of payment decided privately between the parents.

I agree to notify Child & Adult Psychiatrists of the Peninsula (CAPP) of any changes in my account information and understand that a new Financial Responsibility Agreement may then be required.

DUPLICATION OF BILLING STATEMENTS

Please save all billing statements for tax, insurance, and other purposes. A charge may be made for preparation of duplicates at $5.00 for monthly statements and $25.00 for statements covering more than a one-month period.

If you have questions or concerns about any of these issues, we encourage you to discuss them with your therapist. Thank you.

I have read and agree to the above. I have received a copy of this agreement.

Signature: _____ Date: _____

Relationship to patient: _____