

Pediatric Behavioral Health, LLC

Fee Agreement and Cancellation Policy

By signing this document, I am entering a contract Pediatric Behavioral Health, LLC regarding payment of fees for services rendered.

1. FINANCIAL RESPONSIBILITY:

I acknowledge full financial responsibility for services rendered at Pediatric Behavioral Health LLC. Payment of these charges is collected at the start of each session. I understand that any charges incurred by Pediatric Behavioral Health associated with collection of payments (e.g., insufficient funds, collections costs, denial of insurance benefits) will be forwarded on to me.

2. CANCELLATION / NO SHOW POLICY:

As appointments that are cancelled with less than 24 hours notice typically can not be filled with other clients, **any cancellation made with less than 24 hours notice or any appointment missed will result your being charged for the appointment.** Rates are \$35 for appointments cancelled with less than 24 hours notice and the full cost of the appointment will be incurred if an appointment is missed without notification. These charges are not billable to any insurance company. Appointments cancelled due to inclement weather, family illness or family death will not incur a charge.

3. SERVICE TERMINATION:

I understand that if I do not make payments for services, that Pediatric Behavioral Health LLC reserves the right to suspend treatment, upon appropriate notice, and will assist in making a referral elsewhere. If treatment is to be terminated we will treat you for a brief period of time until another provider is identified, and we will send copies of your record to your new provider upon receipt of your authorization to do so. Even if treatment is to be terminated or transferred elsewhere, in the event of an emergency we will provide appropriate and necessary care.

I have read and fully understand and agree to the above fee agreement and cancellation policy.

Client's Name: _____ DOB: _____

Responsible Party's Name: _____

Responsible Party's Signature: _____ Date: _____

Responsible Party's Social Security #: _____

Witness Signature: _____ Date: _____