



FINANCIAL RESPONSIBILITY & PRACTICE POLICIES

Transparent Fees | Clear Expectations | Focused on Your Care

1 PAYMENT & INSURANCE

I understand I am responsible for applicable copayments, deductibles, coinsurance, non-covered services, self-pay charges, and other permitted patient-responsibility amounts. Insurance verification is not a guarantee of payment.

2 CANCELLATION & NO-SHOW POLICY

Required cancellation notice: _____

Late cancellation fee: _____

No-show fee: _____

3 LATE ARRIVALS

Late arrival may shorten the available visit or require rescheduling when the clinician cannot safely complete the necessary assessment within the remaining time.

4 REFILLS / FORMS / ADMINISTRATIVE REQUESTS

Medication refills, letters, disability paperwork, school/work forms, prior authorizations, and other administrative requests may require processing time, an appointment, or an administrative fee when permitted.

5 OUTSTANDING BALANCES

Unpaid balances may affect scheduling or non-emergency administrative services to the extent permitted by applicable law and payer contracts.

6 PATIENT ACKNOWLEDGMENT

Patient / Responsible Party Name: _____

Signature: _____

Date: _____