

**Weston PsychCare, P.A.
2625 Executive Park Drive
Suite 3
Weston, Florida 33331
954-385-4696**

**PSYCHOLOGICAL, BEHAVIORAL AND OCCUPATIONAL SERVICES
FINANCIAL CONSENT**

I, _____, am choosing to enter into services with therapist _____. I understand that Weston PsychCare, P.A. is comprised of INDEPENDENT CONTRACTORS who are each solely responsible for their own professional practice. The practitioners are not laible for the practice of others at the office.

As my appointment time has been set aside EXCLUSIVELY for me, **I understand that I am responsible for the session fee if I fail to cancel a scheduled appointment at least 24 hours in advance.** I understand that Weston PsychCare, P.A. cannot bill insurance companies for failed appointments. Therefore, I will be responsible for BOTH my copayment and my insurance company's reimbursement portion.

I understand that payment or copayment is due at the time that services are rendered, unless explicit arrangements have been made with my clinician. I understand that despite the office's best efforts to bill my insurance company, this does not guarantee claims will be paid. I am responsible for ANY and ALL unpaid balances not covered by the insurance company. Further, I understand that benefits quoted by the insurance company are never necessarily without error. Any information obtained by Weston PsychCare, P.A. about my insurance is not a guarantee of my financial responsibility.

Any balance overdue more than thirty days will be subject to a \$25 late fee PER MONTH. I agree to pay the cost of any delinquent bill, including attorney's fees. I understand that my account may be sent to a collection agency or court if fees are not paid in a timely fashion. If such action becomes necessary, I will be informed of such intent and I will be given an opportunity to settle the balance. If such action becomes necessary, only information to secure payment will be released. All other information will remain confidential.

I fully understand and agree to the above policies and conditions.

Patient/Guardian Signature

Date