PATIENT INFORMATION REGARDING PROFESSIONAL FEES

The purpose of this agreement is to allow us to focus on what is most important to all of us - helping you. It will also help in maintaining a lower fee schedule and clarifying your responsibilities.

I understand that payment is expected **at the time of delivery of service.** I authorize Dr. Rachel Winer to charge my credit card.

My credit card number is _____Exp:_____CVV:_____
__Visa __MasterCard __Discover

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. NO EXCEPTIONS WILL BE MADE. All cancellations are to be **CALLED** by phone. Feel free to leave a message after hours and on weekends to avoid a late cancellation fee.

I AM AWARE THAT INSURANCE WILL NOT COVER CHARGES FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE TO THIS OFFICE ALL INFORMATION NECESSARY TO OBTAIN PREAUTHORIZATION PRIOR TO TREATMENT. I will contact my preferred provider organization (PPO)/managed care company to obtain precertification when required. I agree to advise Dr. Winer when I come in of any change in my address, phone number, marital status, or responsible party that has occurred since my last appointment.

i UNDERSTAND THAT THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED IS MINE AND THAT INSURANCE IS FOR YOUR REIMBURSEMENT. Dr. Winer does not bill the insurance company directly. Your statement contains the information needed to file your insurance.

It is Dr. Winer's policy to designate one parent as financially responsible for services provided to children. If Court Orders (e.g., custody agreements) specify other financial arrangements (e.g., each parent responsible for 50%), it becomes the responsibility of the designated parent to obtain reimbursement from their ex-spouse.

Although interest will not be charged routinely, Dr. Winer reserves the right to charge interest at the rate of 10% per annum and bill for all expenses incurred if your account has to be turned over to collections and/or an attorney.

Please discuss any questions regarding this agreement with Dr. Winer.

By signing below, you indicate that you understand and agree to the information printed above.

_____ _____
Patient's name Date

_____ _____
Responsible Party's Name (Print) Date

_____ _____
Responsible Party's Signature Date