FINANCIAL AGREEMENT
Ruth H Steinman, MD

Ruth H Steinman, M.D. is a private practice psychiatrist.

Professional Fees:

☐Payment in full is due at time of service. Payments may be made with cash, check , Visa or Mastercard
☐Special financial arrangements must be discussed **prior** to your appointment.
☐Parents/Guardians are financially responsible for payment for services provided to minors, or other legal dependents.
☐$25 processing fee will apply for any returned check.
☐Fees may include charges for other professional services such as
1. Report writing
2. Extended telephone conversations
3. Consulting with other professionals
4. Preparation of records or treatment summaries
5. Psychological testing
6. Legal proceedings, including preparation time and transportation

Payment for Services:

I understand that I, not my insurance company, am responsible for full payment of my fees.

I understand that I am responsible for payment of any balances on my account. If my account is referred to a collection specialist, I will be responsible for actual collection costs incurred, including all attorney's fees and court costs. Dr. Steinman may deny subsequent patient treatment if my account balance remains unpaid.

Policy for Missed Appointments and Cancellations:

Appointment times are reserved exclusively for you; If you do not cancel your appointment within 24 hours of the appointment time, you will be charged the full amount of the scheduled time. To avoid any missed appointment or late cancel fees, please call 24 hours in advance to make any changes to your appointment.

I agree that I must give proper notification to cancel an appointment to avoid any late cancellation or missed appointment fees. I agree to call at least **24 hours** in advance to cancel or change my appointment. For Monday appointments, I will call the previous **Friday by noon.**

Information about Shared Office Space:

I share office space with other health professionals. Although we share certain office expenses, I am completely independent in providing you with clinical services, and I alone am responsible for those services. My professional records are separately maintained and secured; I alone have access to those records.

BY SIGNING THIS FINANCIAL AGREEMENT, I HAVE READ ALL ITEMS AND ACCEPT THE TERMS

_____
Patient or (Authorized Parent/Guardian Name) **Printed**

_____ _____
Patient or Authorized Parent/Guardian signature Date