**FINANCIAL AGREEMENT**

**Ruth H. Steinman, MD**

Ruth H. Steinman, MD is a private practice psychiatrist.

**Professional Fees**:

* Payment in full is due at time of service. Payments may be made with cash, check, credit card (Visa/MC/Discover but not Amex)
* 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. Preparation of records or treatment summaries
4. Legal proceedings, including preparation time and transportation

**Payment of 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**:

* I understand that appointment times are reserved exclusively for me. If I do not cancel my appointment within 24 hours of the appointment time, I will be charged the full amount of the scheduled time. To avoid missed appointment or late cancel fees, I agree to call 24 hours in advance to make any changes to your appointment.
* For Monday appointments, I will call the previous Friday by noon.
* I understand that this practice requires a credit card number stored via encryption in your chart to be used in the event of a late cancellation or no-show appointment

**Information about Shared Office Space**:

Dr. Ruth Steinman shares office space with other health professionals. Although she and the other clinicians share certain office expenses, Dr. Ruth Steinman is completely independent in providing clinical services, and she alone is responsible for those services. Dr. Ruth Steinman’s professional records are separately maintained and secured. She alone has access to those records.

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

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Patient or Authorized Parent/Guardian Name Printed

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Patient or Authorized Parent/Guardian Signature Date