

PAYMENT POLICY

PAYMENT IS EXPECTED AT THE TIME OF VISIT. Unless prior arrangements have been made, any accounts that are **30 days past due** will be referred to a collection agency for further handling. An itemized bill will be provided for submission to your insurance carrier. However, it is **your** responsibility to submit the claim for reimbursement.

I UNDERSTAND THAT APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE OR THERE WILL BE A CANCELLATION CHARGE IN THE AMOUNT OF THE FULL FEE PER SESSION. I ACCEPT THIS CANCELLATION POLICY AND AGREE TO BE RESPONSIBLE FOR ANY CHARGES DUE TO A LATE CANCELLATION.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such care to third party payers and other healthcare practitioners.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

In the event a psychological evaluation is required, I understand I will be required to complete forms for which I will be billed separately.

Any blood drawn in this office is sent to an outside laboratory for analysis and processing. I understand that I will be billed separately for these services and agree to pay the laboratory directly.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

FOR YOUR CONVENIENCE WE OFFER THE FOLLOWING METHODS OF PAYMENT:
CASH _____ CHECK _____ CREDIT CARD: MC _____ VISA _____

I hereby authorize the Wilkins Center and Dr. Diane Mickley to keep my signature on file and charge my Credit Card for all services rendered. I understand that this authorization is valid until such time that I cancel the authorization through written notice to the Wilkins Center and Dr. Diane Mickley.

CARDHOLDER'S NAME: _____
ACCOUNT NUMBER: _____
EXPIRATION DATE: _____

CARDHOLDER'S SIGNATURE _____
DATE: _____