

KAY PSYCHIATRIC CENTER PLLC

14405 WALTERS ROAD SUITE 1005 HOUSTON, TX 77014

Phone: (832)952-9688

Fax: 832-210-2639

Email: info@kaypsychiatry.com



FINANCIAL AGREEMENT

Payment for Services:

I understand it is my responsibility to know what services are covered by my insurance plan. I have carefully reviewed the section in my insurance coverage that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or are denied by my insurance plan.

I will provide full and accurate insurance information **in advance** of my appointment or will pay for the appointment on a self-pay basis. I will present my insurance card and proper identification at the time of my appointment. **I will provide updated insurance information prior to my appointment in the case of any changes.**

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party. I understand that, if after 90 days, my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if insurance payment arrives at a later date.

I authorize Sandra Kolapo, MSN, PMHNP-BC to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to Sandra Kolapo, MSN, PMHNP-BC. I understand that I am responsible for payment of any balances on my account.

Policy for Missed Appointments and Cancellations:

Appointment times are reserved exclusively for me. To avoid any missed appointments or late cancellation fees, I will call 24 hours in advance to make any changes to my appointment.

I agree that I must give proper notification to cancel an appointment to avoid late cancellation or missed appointment fees. **I agree to call at least 24 hours in advance to cancel or change my appointment.** Appointment no-shows and appointments cancelled within **24 hours** will be charged a fee of \$100.00

I acknowledge that more than 2 no-shows and more than 3 late cancellations may result in my termination of treatment by Sandra Kolapo, MSN, PMHNP-BC.

BY SIGNING THIS AGREEMENT, I CONFIRM I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY ALL ITEMS AND TERMS SET HEREIN.

Printed name of patient

Printed name of parent/guardian

Signature of patient or parent/guardian

Date: ___/___/___

