Steven E. Locke, MD

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FINANCIAL AGREEMENT

PATIENT'S NAME		DOB	

Insurance coverage varies widely and it is your responsibility to understand the terms and limitations of your policy. Co-payments and payments to meet insurance deductibles are your responsibility. In certain situations there may be perceived advantages to not using your insurance to pay for your sessions – you may elect to self-pay by credit card, cash or personal check. Clients paying on a self-pay basis are expected to pay in full at time of service unless a payment plan has been arranged in advance. My practice manager, Susan Brown, will send you an invoice by mail where you will have the option to pay by credit card, online secure invoice (Stripe) or check.

Sessions are by appointment only. If there are any cancellations or changes that you need to make to your scheduled appointment, at least a 24-hour advance notice is required. Please note that if the 24-hour policy is not honored, you will be charged for the time reserved for you at my customary fee. Insurance companies cannot be billed for missed appointments.

By signing below, you agree to assume full responsibility for, and agree to pay on demand, all costs, charges and expenses of my services provided to you. No extensions granted to you, fee waivers or reductions and no delays or lack of diligence in enforcing any rights against you, shall in any way release you from your obligations or act as a waiver of any subsequent failure to make payment. *If you are experiencing hardship that is interfering with your current ability to pay your bill or possibly become a problem in the future, please contact me as soon as possible so that we can discuss your circumstances and possibly make alternative arrangements.*

I have read this Financial Agreement and understand that I am agreeing to be personally responsible for the charges on my patient account. I understand and agree that payment in full is due at the time services are rendered.

I am providing my credit card information below to guarantee payment for services provided or time reserved, or in the event that there is a delinquent payment for services provided. Delinquent payments beyond 30 days will be assessed a fee of 1% per month service charge or, if necessary, the costs of collection.

VISA / MC / AMEX		EXP	/	CVV		ZIP	

Patient/authorized representative:

PRINT NAME		
EMAIL		
SIGNATURE		DATE