

FINANCIAL TERMS: INSURANCE COVERAGE CO-PAYMENT

You are responsible for obtaining prior authorization for treatment from your insurance company, However, You are responsible for co-pay amounts and deductibles as set by your benefit plan. Co-pays are due and payable at the time of your appointment before seeing the Provider.

Thereby irrevocably assigned to Pacific Neuropsychiatric Specialists and/ or (Dr. Gus Alva, Dr. Kellogg, Dr. Alex Alva, Dr. Mann) all payments for medical services rendered and all mayor medical benefits. I fully understand that I am financially responsible for any charges not covered by an authorization. If at any time during me treatment I become aware that I am ineligible for insurance coverage, I understand I will be financially responsible for 100% of the outstanding bill. I also undertake to inform Pacific Neuropsychiatric Specialists at the earliest of any changes in my personal and or insurance information.

INITIALS.....

CANCELLATIONS AND MISSED APPOINTMENTS

Scheduled appointment times are reserved specially for you. If an appointment is missed or is cancelled with less than 24- Hour workday notice, you will be directly billed according to the applicable fee. Missed appointments are not covered by your insurance and charges associated with them are your responsibility. Repeated "NO SHOW" appointments without sufficient and valid cause will lead to discontinuation of service.

I understand that I will be charged up to \$25 (twenty five) for failed follow-up sessions and that this agreement will remain in effect for the entire duration of my treatment

INITIALS.....

ADDITIONAL AND/OR UNCOVERED SERVICES

I understand that I will be charged at the regular hourly rate of \$350 (three hundred and fifty) for services required outside of the treatment session. These will include consultations with other professionals. I will be charged a fee of \$150 (one hundred and fifty) for follow up appointments. I will be charged a fee of \$25 for any disability forms conservatorship petitions, or any letter that is required for a medical leave etc. from work, school or other related areas.

I have read and agree to the above commitments.

Signature.....

Date.....