PATIENT FINANCIAL AGREEMENT

Please complete the following:

Name _____ (**MR#**_____)

DOB_____ **Date**_____ **Sex M F**

I understand that Catalina Foothills Pediatric Psychiatry is a self-pay practice, and insurance is not billed for services provided by Dr. Weibrecht. I agree to be personally and fully responsible for payment of services rendered by Dr. Weibrecht. I have reviewed (and know I may receive a copy of) Dr. Weibrecht's office policies as well as her fee schedule and understand that if I miss an appointment or cancel less than 48-hours in advance I may be charged full fee or part thereof. **I also understand that charges for missed or late-cancelled appointments may not be billed to insurance, and they will be my responsibility.** I understand that I may make payments by check, cash, HSA, or credit card, and that the returned check fee is $30. I am aware that Dr. Weibrecht's office will make a good faith effort to notify me one month in advance of any fee changes.

Patient Signature _____ **Date** _____