SAN FRANCISCO PSYCHIATRY

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POLICY ACCEPTANCE/CREDIT CARD AUTHORIZATION

Welcome to San Francisco Psychiatry! It's an honor to provide you with personal and attentive psychiatric care!

POLICY ACCEPTANCE

1. I authorize San Francisco Psychiatry (SFP) to contact me about my psychiatric care at the following:

Email: _____

Phone: _____

2. I understand that appointments start at their scheduled time and appointments will not run late if I am not on time for a scheduled appointment.

3. I understand that there is a 50% charge for appointments not cancelled/change by midnight (by either email or voicemail) two days prior to the appointment (e.g. by Tuesday midnight to cancel/change a Thursday appointment).

4. I understand that lost prescriptions for Schedule II controlled substances (e.g. ADD medications) will not be replaced.

5. While being treated by SFP, I agree that any psychiatric medications I am taking will be prescribed by SFP and not by other providers, in the interest of patient safety (i.e. I agree to not get psychiatric medications from more than one prescriber).

_____ _____
Signature of Patient Date

CREDIT CARD AUTHORIZATION

San Francisco Psychiatry keeps credit card numbers securely on file for all patients. Charges are billed on the day of service.

I, _____, authorize San Francisco Psychiatry to charge my credit card to pay for my appointments and any other charges incurred for psychiatric treatment. I am at least 18 years old and am legally authorized to use the credit card account number specified below. I authorize San Francisco Psychiatry to accept updated account information verbally. If the information below changes, I will let San Francisco Psychiatry know.

Card Type: Visa MasterCard Discover American Express

Credit Card # _____ Expiration _____/_____

Security Code (3 or 4 digits) _____

Name (as it appears on the card): _____

Billing address _____

_____

_____ _____
Signature of Card Holder Date