Financial and Appointment Adherence Agreement

1. Fees for services:
   a. Psychiatric Evaluation (45-60 minutes) - $300
   b. Medication Management follow-up (15-20 minutes) - $145
   c. Psychotherapy (30 minutes) - $210
   d. Psychotherapy (45 minutes) - $250
   a 3% service charge will be added when using a credit/debit card for payment
2. All patients are required to pay in full for the service rendered at the time of the appointment. Refunds will not be issued under any circumstances.
3. **Cancellation policy:** Appointments must be cancelled **at least forty-eight (48) hours** in advance of your scheduled appointment or you will be charged the ***full amount*** for the scheduled service. We can be notified of your intent to cancel an appointment by office voicemail (504-800-6750), email (admin@kramerpsychiatric.com), or through the patient portal. Reminder calls and/or emails to our patients are not guaranteed and are offered as a courtesy only.
4. We have the right to discharge patients at any time. However, patients who miss two (2) or more appointments without 48-hour notification or are 10-minutes-or-more late for their scheduled appointment on two (2) or more occasions will be discharged automatically and mailed a written letter of notification.
5. Questions: You are encouraged to call our office if there are any questions about this information. If financial problems arise at any time while under the care of Kramer Psychiatric Services, you are encouraged to speak with our office.
6. Payment for services can be made by cash, check, or credit/debit card. Checks should be written to Kramer Psychiatric Services, LLC.
7. Checks that are not cleared by the bank for any reason will be assessed a $35 service charge. A charge will then be made to the credit card we have on file for you to cover the amount of the check and the service charge. All bad checks written are subject to collection action and will be prosecuted by the Jefferson Parish District Attorney's office to the fullest extent of the law. All fees and costs associated with collections and prosecution will be the sole responsibility of the patient.

***** By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information. *****

Patient Name: ____ Date of Birth: ___________

Signature: ____ Date: ____________