RENÉE BIBEAULT, M.D.

PSYCHIATRY FOR WOMEN

FINANCIAL AGREEMENT

PAYMENT AND BILLING

Payment in full is expected at the time of service. I accept PayPal, Venmo, Zelle and major credit cards. Cash and checks are not accepted. I'm not a network provider with any health insurance plans. If you wish to submit a claim to your insurer to access any out-of-network benefits you may have, my office will provide the necessary document. You agree to have your credit card info stored securely via encryption for future use. You can revoke this permission in writing. You understand that I do not bill insurance and have formally "opted out" of Medicare. I cannot bill Medicare, even at your request, for any services rendered.

Initials _____

CANCELLATION/NO SHOW AND OTHER FEES

I require 48 hours' notice to cancel or change any appointment. Without adequate notice, the full appointment fee will be charged, regardless of the reason for cancellation. Patients are expected to pay their late cancellation or no-show fees before scheduling any further appointments. You agree you've had any questions about this policy satisfactorily answered and will abide by this policy.

Initials _____

EMAIL CONSULT FEES

I welcome you to email me for purposes of scheduling and other housekeeping issues, or for clarifying minor details of care already discussed during an appointment. If you email me more involved questions about your treatment that require my clinical judgment or expertise, I will charge an email consultation fee of $75 before responding. You can decline the consultation and instead request an appointment to discuss your questions/concerns.

Initials _____

COLLECTIONS

You agree that if you default on any payment and your account is referred for collections, you will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees.

Initials _____

FINANCIAL RESPONSIBILITY

You accept that I do not bill insurance and you agree to be responsible for payment at each appointment. You've had the opportunity to review the service fees listed on the practice website and accept financial responsibility for all charges related to your treatment with me.

Name (please print) _____

Signature _____ Date _____

SUBMIT