Dr. QUINTAL & Associates
COUNSELING CENTER
9050 58th Drive East Lakewood Ranch FL 34202
941-907-0525

**FINANCIAL POLICY AGREEMENT**

Fees for service are paid at the time services are rendered. At your request, you will be provided an invoice that you may submit to your insurance company for reimbursement. Please note that Dr. Quintal and Associates, do not interact with insurance companies on your behalf. For your convenience we do accept Visa, Master Card, Discover, American Express, cash or personal checks.

Since a 48 hour notice is required for cancellation of an appointment, you will be charged up to the full fee of service for a session if the cancellation is made with less than a 48 hour notice or if you do not show for your appointment.

Checks returned for insufficient funds are subject to prosecution under the laws of the State of Florida. You will be charged a $25.00 service charge on any returned check. Please note that this office does refer delinquent accounts to a collection agency when satisfactory arrangements cannot be made and our provider/patient relationship may be affected.

We hope this statement of policy will be helpful to you in understanding your financial obligations to this office. Please sign below to acknowledge your understanding and agreement.

**CONSENT FOR TREATMENT**

I certify that the information on this form is correct and I authorize Dr. Quintal and Associates to correspond as agreed and deliver professional psychological services to me and/or my dependent family members, as stated above, if applicable. I understand I may terminate services at any time I wish. I agree to pay the agreed upon charges in full. I authorize release of psychological records necessary to collect fees for services from other third party payors. The fee for services will be at the full fee or contracted fee arranged between patient and Dr. Quintal and Associates. **I understand I may be charged the full fee for services if a scheduled appointment is not kept or is canceled with less then a 48 hour notice.** I certify that I understand the above information and have had the opportunity to ask questions for clarification as needed.

I authorize Dr. Quintal and Associates to provide me with psychotherapy services. I make this request freely and without coercion. **If I give permission for a recording to be made of my session this material may be referred to in writing or used in providing training to individuals who are learning to use this process.** I understand I may terminate services at any time. I understand I will be informed of the benefits and risks of treatment. Additionally, I understand that Dr. Quintal and Associates will provide professional experience and pertinent information concerning their licensing status (Scope of Practice).

I hereby acknowledge that I have been given an opportunity to read and receive a copy of the HIPPA Notice of Privacy Practices and that any questions I had have been answered. If I have further questions regarding the Notice or my privacy rights, I can contact Dr. Quintal and Associates.

I have read the financial policy agreement, confidentiality disclosure, and office policies concerning urgent care, appointments, and fees. I understand my provider and myself will review treatment and I am encouraged to ask questions concerning treatment at any time during the treatment process.

_____ _____
Patient Signature Date

_____
Printed Name

Address _____ City, State, Zip_____

Phone Hm _____ Cell _____ DOB _____

Social Security # _____ Email Address _____

Credit Card Number _____ Expiration Date _____

How would you like to be reminded of appointments: (circle one) Phone Email Text Carrier _____