PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS

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PATIENT CONSENT FOR TREATMENT

I have read and understand the **Outpatient Service Agreement (OSA)** that explains policies and procedures regarding emergencies, patient confidentiality, billing, insurance and I consent to treatment under the conditions described. I authorize the release of information to my insurance company (if applicable). I understand that I am ultimately responsible for the balance due, regardless of how my health insurance may respond to claims. I agree to the OSA described terms regarding interest, collections charges, charges for appointments missed or cancelled, late fees for checks returned unpaid, and payment of costs of collecting delinquent accounts.

Initial Diagnostic Interview

A deposit of $250 is required to schedule an initial appointment. I understand Premier PCC will reimburse me for my insurance benefit and/or apply the difference toward future appointments. **I also understand that If I fail to provide 24 hour notice of cancellation, I will not be reimbursed for the missed appointment.** _______(Please Initial)

Therapy Cancellation Policy

I understand if I fail to appear for my scheduled therapy session, **without providing 24 hour notice of cancellation, my credit card on file will be charged $135**. I also understand if my credit card on file is declined there will be an additional $35 service fee. I understand all fees for missed sessions must be paid prior to my next therapy session. ________ (Please Initial)

TMS Cancellation Policy

I understand if I fail to appear for my scheduled TMS session **without providing 24 hour notice of cancellation or calling ahead for a same-day reschedule, my credit card on file will be charged $100**. I also understand if my credit card on file is declined there will be an additional $35 service fee. _______ (Please Initial)

The required credit card to be used to bring my account current if it is not paid from another source 30 days after receiving a statement is provided below. I also authorize PremierPCC/PremierTMS to validate this card by making a nominal charge which will be credited to my account. ________ (Please Initial)

Visa MasterCard Amex (circle one). # __________________________________ Exp: ______

3 or 4 digit Card Security Code___________ Billing zip code for card: _____________

I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY THE TERMS STATED HEREIN.

________________________________ _____________
Patient Signature Date

________________________________ _____________
Legal Guardian (If client is a minor) Date

________________________________ _____________
Financially Responsible Party (If different) Date