PELTS, KIRKHART & ASSOCIATES, LLC

CLIENT FINANCIAL INFORMATION AND AUTHORIZATIONS

CLIENT NAME: _____
Last First Middle Initial

ADDRESS: _____
Street and # City State Zip

TELEPHONE: _____ _____ _____
Home Cell Work
Please note the best number for us to call in order to reach you.

EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

* * * * * * *

If the client is a minor or another party is to be billed, please complete the following:

BILLING INFORMATION

RESPONSIBLE PARTY NAME: _____

RELATIONSHIP TO CLIENT: _____

BILLING ADDRESS: _____
(if different) Street and # City State Zip

TELEPHONE: _____

EMAIL: _____
(if different)

All Pelts, Kirkhart & Associate providers are fee for service and I understand that I am responsible for the cost of treatment. It is my responsibility to contact my insurer to determine any client reimbursable coverage. I and/or my assigned responsible party are responsible for all payments and updating any changes regarding this authorization.

_____ _____
Date Client/Responsible Party Signature

PELTS, KIRKHART & ASSOCIATES, LLC

FINANCIAL POLICY AGREEMENT

We believe that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

1. **ALL** clients are expected to pay in full at the time of service. It is the client's responsibility to contact their insurance company for any and all authorizations and reimbursement determinations

2. **ALL Pelts, Kirkhart & Associate Providers** are **fee for service** and it is understood that the client/responsible party is liable for the cost of treatment. The client/ assigned responsible party is accountable for all payments as well as updating any and all changes regarding financial information and this policy agreement.

3. **MEDICARE OPT OUT:** Pelts, Kirkhart and Associate Providers have formally opted out of Medicare. Therefore, claims for services with Providers **cannot** be filed with Medicare by the client. A Medicare Opt Out Private Contract will be signed and maintained.

4. **APPOINTMENT REMINDERS** are a courtesy provided by our office. All scheduled appointments are the client's responsibility.

5. **CANCELLATION POLICY:** There is a broken appointment charge for any patient who cancels with **less than 24 hour** notice or who does not present at the appointed time. You will be charged **100%** of the total missed appointment fee.

   Please Note: Requests for cancellations or rescheduling of appointments must be done by a representative of the office between 8:30 am and 5:00 pm Monday through Friday. Messages left on the voicemail cannot be honored.

6. **NON-SUFFICIENT FUNDS CHECK POLICY**: An NSF fee of $35 will be charged for all returned checks including any and all bank fees that apply.

7. **SCHOOL OBSERVATIONS** or court-related fees or other services provided out of the office are to be paid in full at the time of the initial appointment or prior to the visit being scheduled.

8. **BALANCES:** You are encouraged to call our office if there are any questions about this information. If there is a credit card on file, outstanding balances will be charged to that card.

9. **QUESTIONS:** You are encouraged to call our office if there are any questions about this information. If, at any time during your course of treatment, problems with this financial policy arise, you are encouraged to speak with your clinician or to contact the Office Manager.

10. **A COLLECTION AGENCY** will be engaged if you have an outstanding balance which we have been unable to negotiate or collect.

For your convenience we accept cash, personal checks, and most major credit cards. I have read and agree with these terms.

Responsible Party:_____ Date:_____

Name of Client:_____

PELTS, KIRKHART & ASSOCIATES, LLC

Client Name:_____ Client Of:_____

Appointment Reminders

Email reminders for clients of Dr. Pelts, Dr. Wuttke & Dr. Hayne are sent from

DoNotReply@myscheduler.net

Appointment Reminders

Email reminders for clients of Dr. Kirkhart, Dr. Labat, Dr. Blackell, Dr. Asher, Lee Hoffman, Nancy Timm & Renee Boyer are sent from

No-reply@simplepractice.com

(please add addresses above as an allowed address in your email settings to make sure they are received)

Dear Client,

As a client of Pelts, Kirkhart and Associates, you can receive an appointment reminder to your email address, or your cell phone, or text message for reminders from Simple Practice two days before your scheduled appointments. Any changes to your scheduled appointment must be made by phone prior to 5 pm on the previous business day.

Your email address: _____

Your cell phone number: (_____)_____-_____

Your cell phone carrier (circle one):

AT&T Alltell Sprint Boost Mobile Nextel

T-mobileVerizon VoiceStream (Other) _____

I would like to receive my appointment reminders: (Choose as many as you like.)

____ Via email message to the address listed above and

____ Via text message to my cell phone (normal text message rates will apply)
not currently available for Dr. Pelts, Dr. Wuttke, or Dr.Hayne.

____ Via telephone message to my cell (please make sure voicemail is available to leave msg)

____ None of the above. I'll remember my appointment on my own.
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. Appointment reminders are a courtesy offered by Pelts, Kirkhart and Associates with the client being responsible for missed appointments and associated fees.

_____ _____

Client / Parent Signature Date

PELTS, KIRKHART & ASSOCIATES, LLC

Client of: _____ Client of: _____

CREDIT CARD AUTHORIZATION FORM

Client Name: _____

Cardholder's Name: _____

Card number: _____

Type of card: _____ Expiration Date: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

CVV Code: _____

☐ Use for All Sessions (when card is not available) ☐ One Time Use Only

_____ _____
Cardholder Signature Date

_____ _____
Other Authorized User Relationship to Client

I authorize the use of this credit card for payment as a convenience when the actual credit card is not available at time of service. This card may also be used for missed appointments and balances on account. I will update this information as needed.