Maegen S. Vincent, MD, LLC
Maegen S. Vincent, MD (she/her)
Adolescent, Young Adult, and Reproductive Psychiatrist
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Payment Policy

I authorize Maegen S. Vincent, MD, LLC to charge my payment/credit card for payment for my appointments; I understand that full payment for the agreed upon appointment type will also be collected for any late appointment cancelation (notice given <24 business hours, M-F, excluding holidays) or "no-shows" for appointments (>15 minutes late). I also authorize Maegen S. Vincent, MD, LLC to keep my payment card information on file for future use and to charge my card for such purposes. **Any future charges will not require my verbal or written permission prior to collection of payment.**

I understand that **this authorization can be canceled at any time by my request in writing**; however, the cancelation will not affect any payments already charged prior to the receipt of the cancelation notice. I also agree that it is my responsibility to ensure that Maegen S. Vincent, MD, LLC has received any cancellation notice that I may provide**. I agree to inform the practice of any change in my address, phone number, or responsible party that has occurred since my last appointment.**

Payment card information is safely stored on the Stripe payment processing system within the Osmind Electronic Medical Record. There is a **$25 fee assessed for any declined payment card**. If my account has payment overdue for over 60 days, Maegen S. Vincent, MD, LLC has the option of using legal means to secure payment, including collection agencies or small claims court and may include termination of the patient-physician relationship.

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELATIONS WITH LESS THAN 24 BUSINESS HOURS NOTICE. I am aware that insurance will not reimburse charges for missed appointments or late cancellations. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES PROVIDED.

_____ _____

Patient's or Guardian/ representative's signature | Date and time of signature

_____ _____

Print name of patient | Print name of guardian/representative