Keturah Health llc
Medical and Mental Health Clinic
1420 Valwood Parkway Ste. 170a
Carrollton, Texas 75006

Financial Policy

Document Requests – Minimum $50 fee for any letter or claim paperwork. Payment is due at time of service.

Missed & Cancelled Appointments

Please arrive on time to your appointments. Failure to do so may result in a cancelled appointment with charge. We are only able to see patients at their originally scheduled times. Keturah Health aims to offer the best care possible to our patients. We ask that you please notify us at least 48 hours prior to appointment time for cancellation of appointments. Missed appointments or appointments not cancelled at least 48 hours in advance will be subject to full fee. I understand that medications will only be prescribed at appointments with the psychiatrist and nurse practitioner. Medication will not be refilled outside of session. Call our office in advance to set up a medication management appointment if you feel you will run out before your next scheduled session. **My signature indicates that I understand payment is due at the time of service and that I will pay the full fee for missed appointments or appointments not cancelled at least 48 hours prior to appointment time.**

INSURANCE AUTHORIZATION AND ASSIGNMENT

COMMERCIAL INSURANCE CO. NAME ___________________________EFFECTIVE DATE____________________

POLICY #______________________GROUP #___________________________

I request that payment of authorized insurance company benefits be made either to me or on my behalf to Keturah Health Medical and Mental Health Clinic for all services furnished to me by that physician/supplier. I authorize Keturah Health Medical and Mental Health Clinic or its authorized agent to release services and medical information to Medicare, Insurance Company and or its agents needed to determine these benefits or the benefits to related services. I understand my signature request payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the agency shown. I understand that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient. Office policy requires payment at the time of services. Should the insurance benefit assignment be accepted any non-paid services will be paid by me within 30 days of notification. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of that outstanding balance.

_________________________ Patient Signature   Date ___________________________

_________________________ Printed Patient Name   Witness ________________________

Failure to comply with therapy, including absence from appointments, may result in cancellation or delay of medication refills