Transcultural Care
Olamide Alabi, DNP, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
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Financial Responsibility:

Please provide the following credit card information. **PLEASE NOTE**: This information must be completed. All information is kept confidential and will only be used for missed appointments or to clear up any outstanding balance (over 60 days past due).

Credit Card Number: _____

Exp. Date: _____ CVV Code (3digit code printed on back of card): _____

Zip Code for the Debit/Credit Card listed above: _____

Name (as printed on card): _____

Patient Signature: _____ Date: _____

Please read carefully and initial each of the following:

By signing this form, I am authorizing Transcultural Care LLC, to charge my credit card in the event I fail to show for a scheduled appointment or if I do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance. I am aware that weekends and holidays do not count as normal business hours (appointments on Monday must be cancelled by the Friday before). I understand there will be a fee of $100.00 for each missed follow-up appointment and a fee of $250.00 if I miss my initial intake appointment. I am aware that my insurance will not cover a missed appointment and that I am responsible for this fee. I understand and agree that my card may be charged without me being present. I will not dispute for sessions that I have received or for sessions I have cancelled less than 24 business hours in advance. Initial: _____

If I arrive more than 10 minutes late to an appointment it will be considered a late cancellation / missed appointment and I will be rescheduled for another time. Initial: _____

I further understand that I am responsible for updating my billing information, including changes to my address, credit card information, and insurance information, in the event that this information should change. I understand I am responsible for any fees incurred for a declined credit card transaction. I acknowledge that I am aware there is a $35.00 fee for any declined credit card charge or returned check. Initial: _____

Balances past due for 90 days will be sent to an outside collections agency. Initial: _____

My co-pay, co-insurance, and deductible (when applicable) are due at my appointment time by cash, check, or card (credit/HSA/FSA). I am aware that any balances over 30 days may incur a 1.5% monthly finance charge (18% per annum) and that there is a $5.00 billing fee per appointment, per cycle. It is understood that despite my means of payment at my appointment time, my credit card account will be charged for any outstanding balance over two months (60 days) if there is no response to the statements that are sent monthly. Initial: _____

Printed Name: _____ Signature: _____ Date: _____