

**FINANCIAL AGREEMENT  
ALVIN C. BURSTEIN, M.D.**

Alvin C. Burstein, M.D. is a private practice psychiatrist. Due to the administrative work of filing insurance and constraints of optimum care a limited number of insurance companies will be accepted. Please check our website [www.draburstein.com](http://www.draburstein.com) for current insurance information or call our office.

**Professional Fees:**

- Co-payment or balances are due in full at time of service.
- Special financial arrangements must be discussed **prior** to your appointment.
- Parents/Guardians are financially responsible for payment for services provided to minors, or other legal dependents.
- \$25 processing fee will apply for any returned check.
- Fees may include charges for other professional services such as
  1. Report writing
  2. Telephone conversations
  3. Consulting with other professionals
  4. Preparation of records or treatment summaries
  5. Psychological testing
  6. Legal proceedings, including preparation time and transportation

**Insurance Benefits:**

It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered by my insurance plan.

I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self pay basis. I will present my insurance card at the time of my appointment. **I will provide updated insurance information prior to my appointment in case of any changes.**

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

I understand that, if after 90 days, my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

**Policy for Missed Appointments and Cancellations:**

Appointment times are reserved exclusively for you; If you do not cancel your appointment, you will be charged the full amount of the scheduled time. To avoid any missed appointment or late cancel fees, please call 24 hours in advance to make any changes to your appointment.

I agree that I must give proper notification to cancel an appointment to avoid any late cancellation or missed appointment fees. **I agree to call at least 24 hours in advance to cancel or change my appointment. For Monday appointments, I will call the previous Friday by noon.**

BY SIGNING THIS FINANCIAL AGREEMENT, I HAVE READ ALL ITEMS AND ACCEPT THE TERMS

\_\_\_\_\_  
Patient or (Authorized Parent/Guardian Name) **Printed**

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Patient or Authorized Parent/Guardian signature

\_\_\_\_\_  
Date