Bartholomew Thomas Vereb, M.D., M.A.

Child & Adolescent Psychiatry
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Financial Responsibility Agreement

I, the undersigned have read and agree to Dr. Bartholomew Thomas Vereb's fee policy. I acknowledge full financial responsibility for services rendered by Dr. Vereb, irrespective of any third-party coverage.

In the case of non-payment, missed appointments, or other financial deficiencies, I fully authorize Bartholomew Thomas Vereb, M.D./Dynamic Health Associates, P.A. to charge the following credit card as needed. I understand that this information is fully confidential, and is simply kept on file. It will only be used in rare, exceptional cases as described above, and will not be used for any routine billing or charges.

All such charges will be in keeping with office policy, and will be fully documented. All documentation is immediately provided upon request.

Signature Date

Address of financially responsible party (if different than patient's):

Printed name:_____

Address:_____

City:_____State:_____Zip:_____

Credit Card Information

Credit card: Visa _____ Master Card_____ Discover _____ Am. Express_____

Name on the card:_____
Card number _____
Expiration date _____
Security code _____