DEISY CRISTINA BOSCAN, PHD., A PROFESSIONAL CORPORATION
7590 Fay Ave Suite #401 La Jolla, CA 92037
PHONE: 858-263-4226 – 858-263-4206

FINANCIAL RESPONSIBILITY

RESPONSIBLE PARTY'S INFORMATION (If different from patient)

Responsible Party's Name:	**Relationship to Patient:**
Date of Birth: *(MM/DD/YYYY)*	**Social Security:** - -
Responsible Party's Address:	**City, State, Zip:**
Home Phone: ***Message Ok?*** ☐Yes ☐No **Work Phone:** ***Message Ok?*** ☐Yes ☐No **Cell Phone:** ***Message Ok?*** ☐Yes ☐No	**Marital Status:** ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced

FEE AGREEMENT

I understand the above charges for services and agree to assume responsibility for all charges rendered for myself or my child's care. I understand that for Dr. Boscán I will provide insurance documentation to my insurance company to help with the coverage of all or part of any balance owed to her. I also understand that an appointment commits the doctor's time to me (or my child) and unless a minimum of a 48-hour advance notice is given, I am financially responsible for all cancelled or missed appointments. I agreed to pay any and all fees which are not covered by my insurance company, and to hold Dr. Boscán harmless for any legal claim made by myself or others for non-payment of her fees, my insurance company or other third-party payer. I understand that my account could be transferred to a collection agency for non-payment of fees. If the account is not paid in full in 60 days from the date of service, the balance will begin accruing interest which will be added to the balance due. I authorize the release of information necessary to process insurance claims and assign my benefits directly to Dr. Boscan. I agree to pay my full balance, full co-payment, or fee of _____.

_____ _____ _____
Client's Printed Name Client's / Parent's / Guardian Signature Date

FEES AND CO-PAYMENT AGREEMENT: For your convenience, we will be glad to charge your fee/co-pay to your credit card. You are responsible for knowing the amount of your insurance co-payment is. FEE/CO-PAYMENT $ _____

NAME ON THE CARD: _____ ADDRESS: _____

CITY: _____ ZIP CODE: _____ CREDIT CARD NUMBER: _____

EXPIRATION: ____/_____ SECURITY CODE: _____ SIGNATURE: _____

Please note,
Late Cancellations and No-Show Policies: Please provide at least a 48-hour cancellation notice if you need to cancel or reschedule your appointment. Missed appointments and late cancellations, without a 48-hour notice, will be subject to a cancellation fee.
Office Policy: Psychological Therapy is billed per hour and automatically charged via credit card at the end of the month for services rendered. Statements will be provided per direct request. Psychological Assessments are billed per hour. Payment for services rendered is expected in full before the release of the psychological report.