KRISTE BABBITT, MD, PLLC
4550 Post Oak Place, Suite 320
Houston, TX 77027
(713) 622-5480

PATIENT INFORMATION REGARDING PROFESSIONAL FEES

The purpose of this agreement is to clarify your financial responsibilities and allow us to focus on what is most important to all of us—helping you.

Payment is expected at the time of service. Accepted methods of payment include cash, check, and credit card (Visa, MasterCard, American Express, Discover). Checks should be made payable to **Kriste Babbitt, MD, PLLC**. Having the office charge your credit card at the time of service is encouraged because it simplifies the check out process for you and the office.

I authorize Kriste Babbitt, MD, PLLC to charge my credit card.

My credit card # is_____ Auth #_____ exp. date_____ Zip_____. **(Note**Zip code must be for where the credit card statement is sent to.)**

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. I am aware that insurance will not reimburse charges for missed appointments or late cancellations.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE TO THIS OFFICE ALL INFORMATION NECESSARY TO OBTAIN PREAUTHORIZATION PRIOR TO TREATMENT. I understand I may be charged for the time involved in obtaining preauthorization.

I agree to advise the receptionist when I come in of any change in my address, phone number, marital status, or responsible party that has occurred since my last appointment.

WE WANT TO BE CLEAR THAT THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED IS YOURS AND THAT INSURANCE IS FOR YOUR REIMBURSEMENT. We do not bill the insurance company directly. Your statement contains all information needed to file with your insurance.

Although interest will not be charged routinely, we reserve the right to charge interest at the rate of 10% per annum and bill for all expenses incurred if your account has to be turned over to collections and/or an attorney. Similarly, we will charge to recoup returned check fees.

If you have any questions regarding this agreements, do not hesitate to discuss it with your doctor.

_____ _____
Patient's Name (Print) Date

_____ _____
Responsible Party's Name (if patient, indicate "self") Date

_____ _____
Responsible Party's Signature Date