Cara Erkut, M.D.

New Patient Intake Form

Demographic Information

Patient Name:

DOB:

Age:
Gender:

Preferred Pronouns:

Home Address:

Phone Number:

Email Address:

Alternate Phone Number:

Occupation:

Marital Status:

Emergency Contact Name:

Relationship:

Phone Number:

Who referred you to the clinic?

Health Insurance Information

Plan Name (if we do not have it):

Member ID (if we do not have it):

Group Number (if we do not have it):

*Please include a copy of the front and back of your insurance card

Mental Health Information

Please briefly describe what brings you to see me:

Psychiatric Review of Systems

Are you experiencing any of the following symptoms? Check all that apply

Depression

- Depressed mood
- Lack of joy
- Excessive guilt
- Fatigue
- Difficulty concentrating
- Decreased appetite or overeating
- Suicidal thoughts
- Decreased libido

Anxiety

- Excessive anxiety
- Difficulty controlling worry
- Restlessness or feeling on edge
- Fatigue
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance

Panic

- Palpitations, pounding heart
- Sweating
- Trembling
- Shortness of breath
- Feeling of choking
- Chest pain or discomfort

- Nausea/abdominal distress
- Dizziness, lightheadedness, feeling faint
- Chills or heat sensations
- Numbness or tingling
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying

PTSD

- experiencing or witnessing a traumatic event, learning it happened to a close family member/friend, or being a first responder
- intrusive distressing memories about the event
- nightmares about the event
- re-experiencing (flashbacks) the event
- being psychologically triggered by reminders of the event
- being physiologically triggered by reminders of the event
- avoidance of memories, thoughts, feelings about event
- avoidance of reminders of the event
- inability to remember important aspect of event
- persistent negative beliefs about self or world (I am bad, the world is bad)
- blaming oneself or others
- persistent negative emotional state (fear, horror, anger, shame)
- lack of joy
- detachment from others
- inability to experience positive emotions (e.g. love)
- irritable or angry outbursts
- recklessness
- hypervigilance
- easy startle
- difficulty concentrating
- difficulty sleeping

Do you have any issues with substance use or have you had any issues in the past?

Medications

Please list all medications you currently take and their dosages:

Past Psychiatric History

Have you ever been diagnosed with a mental illness before? If so, please specify.

Have you had outpatient mental health treatment before? Please write the dates and names of all doctors you have seen for mental health treatment.

Have you ever been psychiatrically hospitalized before? Please write the dates of all psychiatric hospitalizations you have had and the reason for the hospital stay.

Have you ever attempted suicide?

Please list all psychiatric medications you have tried in the past, the dates, whether it was helpful, and why you stopped it.

Medication Name	Year you took it	Highest Dose you took	Was it helpful?	Why did you stop it?

Medication Name	Year you took it	Highest Dose you took	Was it helpful?	Why did you stop it?

Medical Information

Do you have any allergies to medications? If so, please specify the medication and the allergy

Do you have any medical problems? Please specify

Have you had any major medical problems in the past, head injuries, or any major surgeries? Please specify and include the date

Family History

Does anyone in your family have a mental illness? Please list the family member and the diagnosis

Cara Erkut, M.D.

Office Policies

Introduction

Welcome to my practice! I am excited to meet you. Before we begin, please carefully review my office policies and bring any concerns or questions to your first appointment. I need all enclosed forms completed. Thank you and I'm looking forward to meeting you! 😊

Credentials

I am a psychiatrist. My primary area of focus is psychiatric medication management and transcranial magnetic stimulation (TMS). I am in independent, private practice within a group called the Center for Anxiety and Depression on Mercer Island, WA.

I am board certified by the American Board of Psychiatry and Neurology. I am also a psychoanalyst. I am on staff at Seattle Children's Hospital. I am licensed to practice medicine by the State of Washington. I have a Federal DEA License for prescribing medications. In my private practice, I offer psychiatric medication management, supportive and psychoanalytic psychotherapy, for adults and adolescents ages 13 and up. I provide transcranial magnetic stimulation (TMS) for adults and adolescents ages 15 and up.

I have subspecialty training in psychoanalysis as well as psychopharmacology training from the Center for Anxiety and Depression with Dr. David Dunner. We specialize in treatment-resistant depression, bipolar, and anxiety disorders. I also have a background in eating disorders. I have additional training in the legal sector and help people who are recovering from work-related injuries, undergoing vocational rehabilitation, or coming out of incarceration.

Education and Experience

I attended undergraduate at UC Berkeley and majored in Biology and Psychology. I attended medical school at the Mayo Clinic. I then completed psychiatry residency at the University of Washington, in Seattle. I completed psychoanalytic training at the Seattle Psychoanalytic Society and Institute. I have worked in a variety of settings including private practice, forensic, consult-liaison, partial hospital, and residential levels of care. Currently, I run the TMS program at the Center for Anxiety and Depression. My primary focus is psychiatric medication management and TMS.

Appointments

The initial appointment is 50 minutes long. This is where I take time to get to know you, learn more about what brings you to treatment, and how I can help. It is a consultation to determine if we are a good fit to work together or if I should refer you to another doctor. I take time before and after the appointment to review your records and gather additional information to make a diagnosis and treatment recommendations.

If I decide that I am not the best doctor to help you, then I will give you a referral. Please be aware that I usually cannot start a treatment plan that needs long-term monitoring if we only meet for one session. However, I am happy to provide my recommendations to your primary care physician or treating provider.

If we decide to work together, we will discuss how often to meet. If you are seeing me for medication management, follow up sessions are generally 20-25 minutes in length. If you are seeing me for psychotherapy and medication management, sessions are 50 minutes in length.

Insurance

I am in-network for the following insurance plans. I am out-of-network for all other plans. I am out-of-network for Medicare, Medicaid, and Apple Health plans.

Regence/Blue Shield

Aetna

First Health

Premera/Blue Cross

LifeWise

Optum Behavioral Health/United

First Choice

On-Call Coverage

Please try to bring your questions to your next appointment. If you need help between appointments and it is a life-threatening emergency such as suicidal ideation, I want you to go to the nearest emergency room and talk to a provider as soon as possible and call the office so that I know what is going on. Call the front desk (206) 230-0330 and leave a message or call my work cell phone (425) 766-1444. I will follow up with you as soon as I can, but since I am usually not available urgently, the safest thing to do is to get help ASAP by calling 911 or going to the emergency room.

You are responsible for ensuring that your prescription refills are up to date before you leave your appointment each time. Please do not make it a habit to call me between appointments for prescription refills. I charge for my time for prescription refills between visits and insurance companies do not reimburse for this.

If you are having a serious medication side effect, I want you to call me. Call the front desk (206) 230-0330 and leave a message or call my work cell phone (425) 766-1444. If it is Monday – Thursday morning, I will call you back as soon as I can. If it is Thursday afternoon to Monday morning, call the on-call doctor. The instructions for the on-call doctor are on our outgoing voicemail every weekend. The on-call doctor is not likely to prescribe controlled substances.

No Show and Cancellation Policy

Please make your best effort to arrive on time for all of your scheduled appointments. Our policy is to send you an email reminder and provide a reminder phone call ahead of the appointment. Given the effort we put in to remind patients of their appointments, if you miss your appointment without notice (e.g. a no-show) or cancel within 48 hours, you must pay the full fee. We will automatically charge your credit card on file for this. Please be aware that insurance companies do not cover this fee. This pays respect to my time, my income, and the fact that I usually cannot schedule another patient during the time I reserved for you within 48 hours. I appreciate your understanding. To cancel or reschedule an appointment, call our front desk at (206) 230-0330 or email us at connect@centerforanxietyanddepression.com.

Work Between Sessions

I conduct my work during your session time. I try to set clear boundaries around that and try not to provide additional work outside of session. This allows me to maintain a healthy work environment and prevents physician burnout. Therefore, if you need additional help outside of session, I recommend scheduling another

appointment to see me. I prefer not to email, text, or talk much by phone unless absolutely necessary such as for a safety issue. This includes acute suicidal ideation or a serious medication side effect. If it is necessary, please be aware that I charge my hourly rate for the time that I spend working for you outside of session to pay respect for my time. Insurance companies do not reimburse for this. If you need letters written, referrals sent, etc. I recommend you request this from your primary care provider as it will be much cheaper than getting it from me. I wish there were a way for me to bill your insurance company for administrative services and unfortunately, at this time, that is not allowed. I prefer not to charge you for administrative services. I am not an attorney. So I request that you keep "between session requests" to a minimum.

Payment

My biller, Janelle Guerrero, owner of NW Billing Solutions, will send you a statement at the beginning of each month by email. Payment is due by the 15th of each month by credit card. We do not accept cash or check. To pay your bill, call Janelle at 877-669-6927 or you can pay online via Square. If we do not receive payment by the 30th of each month, we will automatically charge your credit card on file. Declined credit cards will be assessed a $50.00 fee. Please be aware that we charge 4% interest on all unpaid balances. For all billing questions, please contact Janelle at 877-669-6927 or janelle@nwbillingsolutions.com. If I am in-network for your insurance, we collect the co-pay at the time of service by credit card. If I am out-of-network for your insurance, we collect the full fee at the time of service by credit card.

I have read and understood the office policies of Dr. Cara Erkut, MD PLLC. I agree to the office policies of Dr. Cara Erkut, MD PLLC.

Patient Name: _____

Signature: _____

Date: _____

Legal Guardian Signature: _____

Name: _____

Date: _____

Cara Erkut, M.D.

Release of Information

Please complete this form with the contact information for your other mental health providers such as your psychotherapist, your referring psychiatrist/prescriber, your primary care provider, and any other providers relevant to your care with me. Then I will be allowed to collaborate with them.

Section I

I, _____, give my permission for Cara Erkut, M.D. to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II

Disclose my complete health record including, diagnoses, lab test results, treatment, and billing records for all conditions.

- Yes
- No

Or

I would like to give Cara Erkut, MD permission to disclose my complete health record except for the following information:

Check all information you want excluded

- Mental Health Records
- Communicable Diseases including but not limited to HIV and AIDS
- Alcohol/Drug Abuse Treatment Records
- Genetic Information
- Other please specify: _____

Section III Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

Section IV – Who Can Receive My Health Information

I give authorization for Cara Erkut, MD to disclose the health information detailed in section II of this document to the following individual(s) or organization(s). I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Please write who you want me to contact:

Name: _____

Role: _____

Organization: _____

Phone Number: _____

Address: _____

Name: _____

Role: _____

Organization: _____

Phone Number: _____

Address: _____

Name: _____

Role: _____

Organization: _____

Phone Number: _____

Address: _____

Section V – Duration of Authorization

This authorization to share my health information is valid from _____ to _____ or until treatment concludes.

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to Cara Erkut, MD.

I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Patient Name: _____

Patient Signature: _____

Date: _____

Cara Erkut, M.D.

Medicare Opt-Out Private Contract

This contract is between Cara Erkut, M.D. PLLC ("Psychiatrist") and _____ (Medicare beneficiary, referred to in this contract as "Patient"). Psychiatrist has elected to opt out of Medicare. A psychiatrist who opts out is not required to submit claims on behalf of beneficiaries and is not subject to Medicare limits on charges for covered services.

1. Psychiatrist represents that Psychiatrist opted out from participation in the Medicare program.

2. Patient (or Patient's legal representative) and Psychiatrist agree that Patient is not now facing an emergency or urgent health care situation.

3. By signing this contract, Patient (or Patient's legal representative) does the following:

a. accepts full responsibility for payment of Psychiatrist's charge for all services furnished by Psychiatrist;

b. understands that Medicare limits do not apply to what the Psychiatrist may charge for items or services furnished by the Psychiatrist;

c. agrees not to submit a claim to Medicare or to ask Psychiatrist to submit a claim to Medicare;

d. understands that Medicare payment will not be made for any items or services furnished by Psychiatrist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;

e. enters into this contract with the knowledge that Patient has the right to obtain Medicare covered items and services from psychiatrists, physicians, and practitioners who have not opted out of Medicare, and that Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other psychiatrists, physicians, or practitioners who have not opted out;

f. understands that Medigap plans do not, and that other supplemental plans may elect not to make payments for items and services not paid for by Medicare.

4. The effective date of the opt-out period is: March 13, 2023. The expected expiration date of the opt-out period is: March 13, 2025.

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Psychiatrist's current opt-out period.

Patient or Patient's Legal Representative Signature: _____

Name: _____

Date: _____

Cara Erkut, M.D.

HIPAA Notice of Privacy Practices

Everything you share with me is strictly confidential and considered PHI or protected health information under the Health Insurance Portability and Accountability Act (HIPAA). Even if you are a minor, you must give me permission to disclose your health information to your family members, unless there is a risk to your safety. The times when I have to disclose your health information is when I believe you are at imminent risk of harming yourself, someone else, or if I have reason to believe that a child or vulnerable adult needs protection. In those rare circumstances, I disclose the minimum information necessary to ensure safety. Medical records can be subpoenaed by a judge if there is a legal proceeding. I submit claims to your health insurance and disclose the minimum necessary information for payment. I send bills to any authorized family members who are paying the bill for your treatment. Insurance companies may also perform an audit of your case and review your medical records and I am required to disclose this health information for payment.

The State of Washington allows adolescents age 13 and up to consent to mental health treatment without permission from their parents. With minors, I often request a release of information from the patient in order to discuss medications and safety with the parents as this often helps improve results when young people have family support and understanding. However, it is not required.

I have read and understood the HIPAA notice of privacy practice of Dr. Cara Erkut, MD.

Patient Name: _____

Signature: _____

Date: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Signature: _____

Name: _____

Date: _____

Relation to patient:_____

Cara Erkut, M.D.

Credit Card Authorization

In an effort to better serve our patients and simplify your billing experience, we offer credit card acceptance. Charge card information is filed with your confidential information and kept secure. This is a requirement in order to reserve your time.

I hereby authorize Cara Erkut, MD to charge my card automatically if I no-show for my scheduled appointment, cancel within 48 hours, or do not pay my bill by the 30th of each month. Dr. Erkut charges the full session fee for appointments cancelled within 48 hours and no shows. I am aware that insurance companies do not reimburse for this. There is a $50.00 administrative processing fee for each failed payment should my payment fail. It is my responsibility to ensure a valid card with available funds is on file at all times and to update information accordingly in advance if necessary.

_____ Initial _____ Date

Patient Name: _____

Billing Address: _____

Billing City: _____

Billing State: _____

Billing Zip Code: _____

Type of Card: Visa Mastercard Amex Discover

Card Number: _____-

Expiration Date: _____

Security Code: _____

Card Holder Name: _____

Signature of Card Holder: _____

Date: _____

Being the authorized cardholder, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Dr. Cara Erkut, MD to charge my credit card for any no-shows, cancellations within 48 hours, or balances not paid after the 30th of each month. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. I furthermore confirm that I have received all services and goods to satisfactory conditions.

_____ Initial _____ Date

Cara Erkut, M.D.

Office Policies

Introduction

Welcome to my practice! I am excited to meet you. Before we begin, please carefully review my office policies and bring any concerns or questions to your first appointment. I need all enclosed forms completed. Thank you and I'm looking forward to meeting you! 😊

Credentials

I am a psychiatrist and psychoanalyst. My primary area of focus is psychiatric medication management, transcranial magnetic stimulation (TMS), and relational psychoanalytic psychotherapy. I am in independent, private practice within a group called the Center for Anxiety and Depression on Mercer Island, WA.

I am board certified by the American Board of Psychiatry and Neurology. I am on staff at Seattle Children's Hospital. I am licensed to practice medicine by the State of Washington. I have a Federal DEA License for prescribing medications. I see adults and adolescents ages 13 and up.

I have subspecialty training in psychoanalysis as well as psychopharmacology training from the Center for Anxiety and Depression with Dr. David Dunner. We specialize in treatment-resistant depression, bipolar, and anxiety disorders. I also have a background in eating disorders. I have additional training in the legal sector and help people who are going through work-related injuries, vocational rehabilitation, custody cases, or coming out of incarceration.

Education and Experience

I attended undergraduate at UC Berkeley and majored in Biology and Psychology. I attended medical school at the Mayo Clinic. I then completed psychiatry residency at the University of Washington, in Seattle. I completed psychoanalytic training at the Seattle Psychoanalytic Society and Institute. I have worked in a variety of settings including private practice, forensic, consult-liaison, partial hospital, and residential levels of care. Currently, I run the TMS program at the Center for Anxiety and Depression. My primary focus is psychiatric medication management and TMS.

Appointments

The initial appointment is 50 minutes long. This is where I take time to get to know you, learn more about what brings you to treatment, and how I can help. It is a consultation to determine if we are a good fit to work together or if I should refer you to another doctor. I take time before and after the appointment to review your records and gather additional information to make a diagnosis and treatment recommendations.

If I decide that I am not the best doctor to help you, then I will give you a referral. Please be aware that I usually cannot start a treatment plan that needs long-term monitoring if we only meet for one session. However, I am happy to provide my recommendations to your primary care physician or treating provider.

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Aetna

First Health

Premera/Blue Cross

LifeWise

Optum Behavioral Health/United

First Choice

On-Call Coverage

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aware that I charge my hourly rate for the time that I spend working for you outside of session to pay respect for my time. Insurance companies do not reimburse for this. If you need letters written, referrals sent, etc. I recommend you request this from your primary care provider as it will be much cheaper than getting it from me. I wish there were a way for me to bill your insurance company for administrative services and unfortunately, at this time, that is not allowed. I prefer not to charge you for administrative services. I am not an attorney. So I request that you keep "between session requests" to a minimum.

Payment

My biller, Janelle Guerrero, owner of NW Billing Solutions, will send you a statement at the beginning of each month by email. Payment is due by the 15th of each month by credit card. We do not accept cash or check. To pay your bill, call Janelle at 877-669-6927 or you can pay online via Square. If we do not receive payment by the 30th of each month, we will automatically charge your credit card on file. Declined credit cards and late payments will be assessed a $100.00 fee. If you do not resolve an unpaid balance with me, then I will not continue to serve you as your doctor. For all billing questions, please contact Janelle at 877-669-6927 or janelle@nwbillingsolutions.com. If I am in-network for your insurance, we collect the co-pay at the time of service by credit card. If I am out-of-network for your insurance, we collect the full fee at the time of service by credit card.

I have read and understood the office policies of Dr. Cara Erkut, MD PLLC. I agree to the office policies of Dr. Cara Erkut, MD PLLC.

Patient Name: _____

Signature: _____

Date: _____

Legal Guardian Signature: _____

Name: _____

Date: _____

Cara Erkut, M.D.

Release of Information

Please complete this form with the contact information for your other mental health providers such as your psychotherapist, your referring psychiatrist/prescriber, your primary care provider, and any other providers relevant to your care with me. Then I will be allowed to collaborate with them.

Section I

I, _____, give my permission for Cara Erkut, M.D. to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II

Disclose my complete health record including, diagnoses, lab test results, treatment, and billing records for all conditions.

- Yes
- No

Or

I would like to give Cara Erkut, MD permission to disclose my complete health record except for the following information:

Check all information you want excluded

- Mental Health Records
- Communicable Diseases including but not limited to HIV and AIDS
- Alcohol/Drug Abuse Treatment Records
- Genetic Information
- Other please specify: _____

Section III Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

Section IV – Who Can Receive My Health Information

I give authorization for Cara Erkut, MD to disclose the health information detailed in section II of this document to the following individual(s) or organization(s). I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Please write who you want me to contact:

Name: _____

Role: _____

Organization: _____

Phone Number: _____

Address: _____

Name: _____

Role: _____

Organization: _____

Phone Number: _____

Address: _____

Name: _____

Role: _____

Organization: _____

Phone Number: _____

Address: _____

Section V – Duration of Authorization

This authorization to share my health information is valid from _____ to _____ or until treatment concludes.

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to Cara Erkut, MD.

I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Patient Name: _____

Patient Signature: _____

Date: _____

Cara Erkut, M.D.

Medicare Opt-Out Private Contract

This contract is between Cara Erkut, M.D. PLLC ("Psychiatrist") and _____ (Medicare beneficiary, referred to in this contract as "Patient"). Psychiatrist has elected to opt out of Medicare. A psychiatrist who opts out is not required to submit claims on behalf of beneficiaries and is not subject to Medicare limits on charges for covered services.

1. Psychiatrist represents that Psychiatrist opted out from participation in the Medicare program.

2. Patient (or Patient's legal representative) and Psychiatrist agree that Patient is not now facing an emergency or urgent health care situation.

3. By signing this contract, Patient (or Patient's legal representative) does the following:

a. accepts full responsibility for payment of Psychiatrist's charge for all services furnished by Psychiatrist;

b. understands that Medicare limits do not apply to what the Psychiatrist may charge for items or services furnished by the Psychiatrist;

c. agrees not to submit a claim to Medicare or to ask Psychiatrist to submit a claim to Medicare;

d. understands that Medicare payment will not be made for any items or services furnished by Psychiatrist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;

e. enters into this contract with the knowledge that Patient has the right to obtain Medicare covered items and services from psychiatrists, physicians, and practitioners who have not opted out of Medicare, and that Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other psychiatrists, physicians, or practitioners who have not opted out;

f. understands that Medigap plans do not, and that other supplemental plans may elect not to make payments for items and services not paid for by Medicare.

4. The effective date of the opt-out period is: March 13, 2023. The expected expiration date of the opt-out period is: March 13, 2025.

This contract shall remain in force and effect from the date it is signed by Patient until the end of the term of the Psychiatrist's current opt-out period.

Patient or Patient's Legal Representative Signature: _____

Name: _____

Date: _____

Cara Erkut, M.D.

HIPAA Notice of Privacy Practices

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I have read and understood the HIPAA notice of privacy practice of Dr. Cara Erkut, MD.

Patient Name: _____

Signature: _____

Date: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Signature: _____

Name: _____

Date: _____

Relation to patient:_____

Cara Erkut, M.D.

Credit Card Authorization

In an effort to better serve our patients and simplify your billing experience, we offer credit card acceptance. Charge card information is filed with your confidential information and kept secure. This is a requirement in order to reserve your time.

I hereby authorize Cara Erkut, MD to charge my card automatically if I no-show for my scheduled appointment, cancel within 48 hours, or do not pay my bill by the 30th of each month. Dr. Erkut charges the full session fee for appointments cancelled within 48 hours and no shows. I am aware that insurance companies do not reimburse for this. There is a $100.00 administrative processing fee for each failed payment should my payment fail. It is my responsibility to ensure a valid card with available funds is on file at all times and to update information accordingly in advance if necessary.

_____ Initial _____ Date

Patient Name: _____

Billing Address: _____

Billing City: _____

Billing State: _____

Billing Zip Code: _____

Type of Card: Visa Mastercard Amex Discover

Card Number: _____-

Expiration Date: _____

Security Code: _____

Card Holder Name: _____

Signature of Card Holder: _____

Date: _____

Being the authorized cardholder, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Dr. Cara Erkut, MD to charge my credit card for any no-shows, cancellations within 48 hours, or balances not paid after the 30th of each month. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. I furthermore confirm that I have received all services and goods to satisfactory conditions.

_____ Initial _____ Date