GERALD D. CHITTERS M.D.
PSYCHIATRIST

Please return to:
Phone: 303.545.5380 Fax: 303.402.0445
email: meredith@gdchittersmd.com

Payment in full (if self pay or using my services as an out of network provider) or co-pays/deductibles (if I am an in network provider with your insurance company) is due at time of services.

Your insurance will be billed on your behalf. Any uncovered services, including, but not limited to: copayments, coinsurance, or deductible for scheduled and kept appointments, sessions cancelled without 48-hour notice, telephone consultations, reports prepared outside of appointments and records review.

You will receive a monthly statement for these fees. If you do not remit payment within 30 days of the statement, your credit card will be automatically charged for your balance due.

This agreement shall remain in existence as long as I am a patient of Gerald D. Chitters, M.D. or until I provide a written retraction of this agreement.

Please circle payment method: Visa Mastercard

Patient Name: _____

Card #: _____

Expiration Date: _____

Three numbers on back of card: _____

_____

Card Holder Name

_____

Street address on file with Credit Card account holder

_____

City, State, Zip Code

_____

Cardholder Phone #:

I _____ agree to allow Gerald D. Chitters MD to keep my credit card on file. In the event of my balance becoming 30 days past due I acknowledge that my credit card will automatically be charged for the balance due and I will receive a receipt of the charges incurred.

_____ _____

Cardholder Signature Date