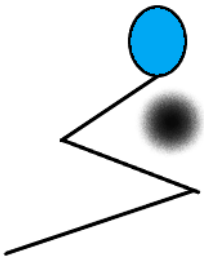

ZenBees Psychiatry and Wellness Services, LLC.
180 Thomas Johnson Drive, #100
Frederick, MD 21702
Phone: 410-693-7401
Fax: 534-429-4341
Email: Zb@zenbeespsychiatry.com

Self-pay Agreement Form

Patient Name: _____
DOB:_____
This agreement form is to better serve individuals who choose self-pay services.

- ☐ Psychiatric evaluation
- ☐ Routine medication management
- ☐ Therapy with medication management
- ☐ Psychotherapy follow up
- ☐ Others: _____

I _____ understand that I am responsible for all the payment for the provided services received at ZenBees Psychiatry and Wellness Services, LLC. I agree to pay my bill at the time of service. I will make payments by cash, or credit card with a valid driver license. I understand that now show/late cancellation charges would apply if I chose to cancel my appointment less than two business days from the appointment time and date. The late cancellation fee is for an initial appointment and follow up appointment. There is no charge if an appointment is cancelled according to office policy, which is minimum of two business days' notice. I understand that if it is necessary to turn my account over to collection, I will also be responsible for any associated costs with collection. I understand that this authorization shall apply to services provided to me, my dependents, and any other person that I have assumed responsibilities by signing below. This statement is effective from this date forward until it has been revoked in writing.

_____ _____

Patient Signature: Date:

_____ _____

Parent/Guardian signature Date

_____ _____

Print Name Relationship to the patient