Synapse Association Inc.
2056 Lyndell Terrace, Suite 130, Davis, CA 95616
Phone (530)924-4038 Fax: (530) 924-4816
www.synapseassociation.com

Office Policy and Fee Disclosure

Please sign below to indicate you have fully read and understood our fees.

1. Returned (Bounced) Check Fee: There is a $35 penalty fee for any returned checks.
2. Paperwork Fee: There is a $25.00 fee for any paperwork submissions or extensions for FMLA, EDD, or HR related documents. If there are multiple agencies the fee will apply for each agency.
3. Late cancellation/No show Fee: We require a 48-hour cancellation/rescheduling notice. Any cancellations or no-shows within this time period, the patient will be responsible for the full cost of the visit. For those patients with insurance, that cost would include not only the copay but the cost the insurance would pay for the visit. The same cancellation policy applies to deep TMS treatments as well.
4. Copayments/Co-insurances: Copayments are due at the time of service and will be collected prior to seeing the clinician. Co-Insurances are billed through your insurance after which you will receive a billing statement in the mail, no payment is due at the time of service.
5. Outstanding Balance Repayment Plan: All patients much pay half of their balance to continue treatment at this office. Patients can continue to pay the rest of their balance through three consecutive equal monthly payments.
6. Collections: If there is a lapse in payment exceeding a 90-day period, patients accounts can be referred to collections and possibly discharged for nonpayment. Should a patient's account be referred to collections, interest rates may apply at the legal rate. Payments may be made via check, cash, or credit/debit card and can be paid at the office or by USPS to the office address.

Credit/Debit Card Agreement

I agree, per policy of Synapse Association, to provide a valid copy of a debit or credit card to be kept on file for purposes of due charges for no show appointments or late cancellations outside of the timeframes disclosed above. I consent for Synapse Association to charge my debit/credit card for any policy violations for late cancellations or no show to appointments whether or not I am present for the transaction. The card will not be utilized for any other payments or fees.

Signature of Patient: _____

Date: _____