Shlakman Psychiatric Services, PLLC
Samantha A. Shlakman, MD MPH
501 Church Street, NE suite 217
Vienna, VA 22180
phone (202) 421-7408
shlakmanpsychiatricservices@yahoo.com
http://www.shlakmanpsychiatricservices.com
1350 Connecticut Avenue, NW suite 1225
Washington, DC 20036

Financial Responsibility Form

I agree that it is my responsibility to pay all fees incurred through this office. Payment is due at the time of service. If payment is not received, I have agreed to allow my credit card to be charged for the outstanding balance.

As it is stated in Practice Policies, "if you provide less than two business days notice to cancel or change an appointment, you will be charged the full appointment rate," (*note: this is different from the copayment amount if you are a Georgetown student utilizing United Health Care Student Resources insurance and if you are a Peace Corps volunteer). If the full appointment rate has not been paid for a missed session, I have agreed to allow my credit card to be charged for the outstanding balance.

Credit Card Type: ______________________________

Credit Card #: ______________________________

Names as it appears on the Card: ______________________________

Expiration date: ____________________

Security Code (3 digit number on the back of the card): __________

Billing Address (Street, City, State, and Zip): ______________________________

____

I certify that the above information is true and correct to the best of my knowledge:

Signature: ______________________________ Date: ______________