POYNER
mental health services
14453 SE 29th Street Suite D
Choctaw, OK 73020
(405) 741-2844

Voluntary Consent for Appointment Reminders

We can now send you appointment confirmation reminders by text message. If you wish to receive these, we require your consent. Please read the disclaimer below then complete it and sign. By signing, you agree that you have read and completely understand this consent. If you need additional information, please ask before signing this form.

I consent to Poyner Mental Health Services contacting me by text message for the purposes of appointment reminders.

I acknowledge that appointment reminders may or may not occur prior to every appointment, and that it is still my responsibility to attend and cancel appointments.
Note: you may cancel text reminders at any time.

I acknowledge that Poyner Mental Health Services will keep only one phone number on file for reminders, and that we will **not** be responsible for contacting any other person for this purpose.

Text messages are generated using a secure platform. I understand that they are transmitted over a public network onto a personal telephone and may not be secure. However, we will not transmit any information that would lead to patient identification.

If my mobile number changes or is no longer in my possession, I agree to notify Poyner Mental Health Services.

Patient Name_____ Date of birth_____

Name of parent/guardian (If applicable) _____

Mobile Number_____ Phone Carrier _____

By signing this voluntary consent form I agree to all the terms and conditions above.

Signature _____ Date_____

Credit Card Consent Form

Poyner Mental Health Services requires all patients to securely store a form of payment by credit card for all patients. You may still choose to pay by cash, check, HSA, or credit card on the day of your appointment. Your credit card information will be kept on file to only be used in the case of past due account balances over 30 days and/or no show fees. Patients who cancel appointments with less than 24 hours notice or do not show for scheduled appointments, will be charged a $50 no show fee.

A $50 No Show fee *WILL* be automatically charged to my credit card if an appointment is not cancelled within 24 hours prior to the scheduled appointment.

By signing below, I understand and agree to the terms of this agreement, agree to pay, and specifically authorize the charging of my credit card as stipulated. I further agree that in the event my credit card becomes invalid, I will provide a valid credit card upon request to be charged for the payment of any outstanding balances owed. Delinquent accounts may be **sent to collections** if a payment plan has not been set up within 30 days of account finalization. The office will contact you a minimum of three times (phone or mail) to notify you of outstanding balances.

Regardless of what an insurance company states they will pay, it is ultimately your responsibility to pay for services.

Patient Name: _____

Signature of Guarantor for Payment: _____ Date: _____

Name on Credit Card: _____

If you would like an unsecured emailed copy of your receipts, please identify the address you would like used below:

_____

Last Four Digits of Card Number ___ ___ ___ ___

This credit card authorization will remain in effect and on file with Poyner Mental Health Services unless revoked in writing and/or until the therapeutic relationship is terminated, at which time authorization to charge your credit card will be revoked unless an outstanding balance remains on your account after termination.