NATALIE BALDWIN
PMHNP-BC

Natalie Baldwin
Nurse Practitioner in Psychiatry PLLC

P: 518-362-7818
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A: 1 Pine West Plz Ste 110
Albany NY 12205

Patient Name: _____ Date of Birth: _____

Please read and sign below to show your understanding and agreement to the following contract terms:

Late Cancellation and Missed Appointments

Mental health care requires the collaborative effort of you, your child, and your provider. When you do not come to your scheduled appointment or cancel your appointment without the required 24-hour notice, not only do you miss an opportunity for treatment but you also deny someone else the opportunity as well.

As a courtesy, reminder calls, texts or emails will go out 2 days prior to your appointment. Please do not rely on this technology to keep track of your appointments as it is your responsibility to attend all appointments on time. If you cannot make your appointment the office requires 24 business hours' notice to change or cancel your appointment. Please be aware that if you need to change or cancel your appointment with less than 24 hours' notice, there will be a late cancellation fee of $75. Missed appointments will be subject to a $100 fee. Payment will be charged to the credit card on file or expected on or before your next scheduled appointment. Insurance companies do not pay for either late cancellations or missed appointments.

Please arrive promptly or be logged on for your appointment prior to or at the time of your scheduled appointment. I make every effort to see you at your scheduled time. A courtesy text link will be sent at the time of the appointment if you are not logged on, if you are more than 10 minutes late to your scheduled appointment you may have to reschedule and will be subject to a late cancellation fee of $75.

Two missed appointments (without notice) in a six-month time period will lead to discharge from the practice.

If there is no contact with this office within 6 months, you will be considered discharged from this practice and will need to return as a new patient based on the availability of the provider.

By signing below, I am acknowledging that I have read and understand the terms set forth above.

_____ _____ _____

Patient or Parent/Guardian(if under 18) *Signature* Printed name Date

Relationship to patient