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**A PROFESSIONAL MEDICAL CORPORATION**

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# PATIENT AGREEMENT

This document contains important information about my professional services and business practices. Please read it carefully. It explains many of your rights and responsibilities and will represent an agreement between , unless it is amended or terminated in writing.

## PROFESSIONAL SERVICES

Treatment may include discussion of issues that are uncomfortable for you. While I am using my best professional judgment for your well-being, I cannot guarantee that you will obtain the results you seek. You have the right to challenge any aspect of the treatment I recommend.

## CONFIDENTIALITY

In general, law protects the confidentiality of all communications between a patient and a psychiatrist and I can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even required to release patients' protected health information without their authorization.

In the following situation, I must take action to protect people from harm, even though that requires revealing some information about a patient's treatment. If I believe that a child an elderly person or a disabled person is being abused, I must file a report with the appropriate agency. If I believe that a patient is threatening serious bodily harm to them or to another, I am required to take protective actions which may include contacting authorities, family members or others who can help provide projections. I will inform you of these reports.

The standards of my profession require that I record and maintain appropriate treatment records. You are entitled to request a copy of any protected health information or any communication from me in a variety of means and locations. You have the right to require that your information be amended or restricted from certain uses and disclosures. While I seek to honor your request, I may decide that it is not prudent for me to agree to your requests.

## FEE POLICY

Charges for psychiatric services are due and payable at the time services are rendered. In the event other arrangements are made, a statement will be mailed to you, with payment due upon receipt. A service fee of $25.00 will be added to your account balance for each personal check

that is returned to us by your bank. Please note that all accounts 30 days past due will accrue interest at 1% per month.

If your account is referred for collection after 45 days, you will be charged reasonable attorney's fee and collection expenses.

If you have health insurance, it should be understood that your policy is a contact between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. You are responsible for the payment of your bill regardless of the status of your insurance claim and do not relieve you of your financial obligation for payment of services.

By engaging in treatment you are agreeing to pay the fee for each 45-minute session at the time of service. If it is necessary for me to make phone calls, review documents as part of my services to you, those services will be charged to you at the same rate as for direct treatment.

## CANCELLATION POLICY

If you need to cancel or reschedule an appointment, please call as soon as possible and not less than 48 business hours in advance to avoid a chare (i.e. canceling a Monday appointment on Friday is not sufficient notice). If you do not cancel at least 48 business-day hours in advance, you will be responsible for the fee for the session. We have this policy because a time commitment is made to you and is held exclusively for you.

## TESTIMONY

If I am deposed or called to testify in court an nay issue, I will be treated as an expert witness. Payment for deposition or court testimony is $____ per day. This fee includes testimony time, preparation and travel time. Payment is required seven (7) days in advance.

Fees will be refunded for cancellations made for testimony only if 48 business-day hours notice is given, regardless of the reason for the cancellation.

Your signature indicates that you have received a copy, read, understood and are will to abide by the above agreement.

_____
Patient/Responsible Party's Name

_____ _____
Patient/Parent Signature Date

_____
Psychiatrist Name

_____ _____
Psychiatrist Signature Date