HARSHAD PATEL, MD PC, **Child, Adolescent and Adult Psychiatry**

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Patient's Name: _____Age:_____ Sex: ____ Grade:_____ DOB:_____
Patient's Address: _____ City: _____ State: _____ Zip: _____
Mother Name: _____ Email: _____ Cell: _____
Mother's Address: _____ Home Ph: _____
Mother's Employer: _____Work Ph: _____
Father's Name: _____ Email: _____ Cell: _____
Father's Address: _____ Home Ph: _____
Father's Employer: _____Work Ph: _____
Name of Insurance: _____ Patient's Insurance ID: _____Group ID: _____

Please review following important information about our professional services.

1. I hereby give my permission to **Harshad Patel, MD** to treat me. I authorize the release and payment of any medical or other information necessary to process insurance claims and assign all medical benefits to Harshad Patel, MD PC for services provided. I understand that I am financially responsible for all the charges, (including co-pays, co-insurance, unpaid insurance claims, no show or late cancellation, preparation of medical report, returned check charges etc,) and authorizes Harshad Patel MD PC to charge automatically to my credit card in file.

2. I authorize Harshad Patel, MD PC to release and request psychiatric/alcohol/substance and medical related information to and from other physician(s) and therapist(s) for co-ordination of clinical care/treatment, payment, and other health care operations.

3. Termination Policy: Normally, Dr. Patel holds a session to terminate relationship with the patient. If it is your decision to discontinue treatment without a session with me, it is the policy of this office that our therapeutic relationship terminates **90 days** after your last visit or earlier if you are non-compliant with follow up & treatment. I acknowledge and understand that Dr. Patel will terminate relationship earlier if we are **non-compliant** with appointments, treatment recommendations or delinquent account more than 30 days.

4. Financial Policies (1) All charges including, no show or late cancellation of $350 for 1st appointment and $140 for follow up appointments will be billed to credit card on the day of the service. (2) Medication prior authorization charge: $25. (3) Returned check charge: $25. (4) Preparation of medical or treatment report: $50 to $100. (5) Copies of medical records will be charged as per state guidelines.

5. Delinquent account: Accounts that become delinquent will be turned to a **collection agency** with debtor's demographics (such as name, address, phone number, date of service, balance due, work information and social security number to report to **the credit bureau**, etc.), unless arrangements have been made. If such **legal action** is necessary, the cost of bringing that proceeding will be included in the claim.

6. Very Important:-I acknowledge that I have reviewed the notice of **HIPAA** privacy practices and I can receive a copy upon request. I have read and agreed to the above policies.

48-HOUR WEEKDAYS CANCELLATION NOTICE REQUIRED; OTHERWISE, YOUR ACCOUNT WELL BE CHARGED

_____ _____
Patient Name Date

_____
Signature of Patient or Legal Representative