

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

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Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Work Ph: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Email: \_\_\_\_\_ Work Ph: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell 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 charges as allowed if not paid by said insurance.
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. In the event that it is your decision to discontinue treatment without a session with me, it is the policy of this office to assume that our therapeutic relationship terminates **90 days** after your last visit or earlier if you are non-compliant. I acknowledge and understand that Dr. Patel will terminate relationship earlier if I am or we are **non-compliant** with appointments, recommendations / follow-up, medication management, laboratory work-up, delinquent account more than 30 days.
4. Financial Policies(1) All charges including, no show or late cancellation of \$350 for 1<sup>st</sup> appointment and \$110 for follow up appointments will be billed to credit card at the day of service. (2) Medication prior authorization charge: \$25. (3) Returned check charge: \$25. (4) Medication refill call to pharmacy: \$20 (5) Preparation of medical or treatment report: \$50 to \$100. (6) 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.

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**48-HOUR CANCELLATION NOTICE REQUIRED; OTHERWISE YOUR ACCOUNT WILL BE CHARGED**

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Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legal Representative