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 the above named child of whom I am the custodial parent or legal guardian. 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 1st 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.

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

_____ _____

Patient Name Date

_____

Signature of Patient or Legal Representative