

CONVENTIONS PSYCHIATRY & COUNSELING CONSENT FOR TREATMENT

Conventions Psychiatry & Counseling offers quality psychiatric services. Effective and efficient provision of treatment requires the following policies to enable these processes.

- ❖ **FINANCIAL POLICY:** We ask that you *plan ahead to pay at the time of service* your co-pay, co-insurance, any deductible not met or any portion you are responsible for. You are responsible for any preauthorization or referrals required by your insurance. If you do not have insurance or your insurance does not cover these services, you will be considered “Self Pay” and payment is due in full at the time of service.

- ❖ **APPOINTMENT POLICY:** All appointments are to be kept to insure consistency in the treatment process. *A fee of \$50.00 will be charged for 1st cancellation without a 24 hour notice or non-appearance for a scheduled appointment. A patient will be charged UP TO the full billable amount for 2nd non-appearance and after, at the provider’s discretion.*

- ❖ **MEDICATION POLICY:** Medication renewal and/or medication adjustment will occur during the medication follow-up session with the prescribing psychiatrist. In the event that a patient needs a refill prior to the next appointment, the office should be notified and given 48 hours to process the request. *Any refill requests phoned in on a Friday or weekend will be processed on the next business day. No medication will be prescribed over the phone routinely. Multiple refill requests called in or refill requests after missed appointments, may be charged to the patient, at the physician’s discretion - \$10.*

- ❖ **PHONE POLICY:** Phone calls to the office may be made at any time. *Phone calls made for treatment purposes may be charged a fee of \$20-\$40, depending on time spent.* Phone calls for scheduling or matters of short duration will not be charged.

- ❖ **GENERAL OFFICE POLICY:** As a service, it is our policy to bill your insurance and to keep accurate and complete records. *A \$25 fee will be charged for copying and release of these records. Letters, documents generated for your request and completion of forms may also be charged a fee of \$20.*

- ❖ **NOTICE OF PRIVACY PRACTICES:** We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please call our office at 630-416-8289. Your signature below is acknowledgement that you have received this Notice of our Privacy Practices.

Patient Signature: _____ Date: _____

Guardian/Parent Signature: _____ Date: _____