A PHYSICIAN/CLINICIAN – PATIENT TREATMENT RELATIONSHIP WILL BE ESTABLISHED IF MUTUALLY AGREED TO UPON COMPLETION OF THE INITIAL CONSULTATION PROCESS. WE DO NOT ACCEPT ASSIGNMENT FOR MEDICARE IN THIS OFFICE. WE DO REQUIRE PAYMENT AT THE TIME SERVICE ARE RENDERED.

AUTHORIZATION

I AUTHORIZE BOCA RATON PSYCHIATRIC GROUP, P.A.(BRPG) TO RELEASE ANY MEDICAL OR PSYCHIATRIC INFORMATION (INCLUDING PSYCHOTHERAPY AND SUBSTANCE ABUSE RECORDS) TO THE HEALTH CARE ADMINISTRATION, MY INSURANCE COMPANY, MEDICARE AND THEIR AGENTS AS NEEDED TO AUTHORIZE THESE BENEFITS OR THE BENEFITS PAYABLE FOR THESE SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND INSURANCE BENEFITS BE MADE ON MY BEHALF TO BOCA RATON PSYCHIATRIC GROUP, P.A. FOR SERVICES FURNISHED BY ITS AGENTS OR PROVIDERS. I ALSO AGREE THAT ANY AND ALL BALANCES WILL BE PAID BY ME, AND THAT PHOTOCOPIES OF THIS FORM WILL BE VALID. I REQUEST THAT THIS INFORMATION ALSO APPLIES TO ALL OTHER INSURANCE COMPANIES.

GOOD FAITH ESTIMATE – FOR PATIENTS WHO PAY PRIVATELY, OUR PSYCHIATRIC FEE PER EVALUATION AND/OR CONSULTATION IS $495.00 FOR THE 1ST HOUR & $750 FOR 1.5 HOURS. THE TYPICAL FOLLOW-UP VISIT IS $268.00 BUT MAY RANGE AS HIGH AS $584.00. PSYCHOTHERAPISTS BILL AT A LOWER RATE. YOU MAY REQUEST A WRITTEN GOOD FAITH ESTIMATE FOR EXPECTED SERVICES.

I UNDERSTAND I WILL *NOT* RECEIVE A CONFIRMATION CALL FROM BRPG, PA REMINDING ME OF MY SCHEDULED VISIT. I UNDERSTAND THAT IF I FAIL TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT 1 FULL *BUSINESS* DAYS TO KEEP A SCHEDULED APPOINTMENT OR CANCEL WITHOUT 1 FULL BUSINESS DAY (24 HOURS) NOTICE, I WILL BE RESPONSIBLE FOR THE FULL NORMAL FEE OF BRPG.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE INSURANCE CARRIER. **I UNDERSTAND I WILL NOT RECEIVE A CONFIRMATION CALL REMINDING ME OF MY VISIT.** I UNDERSTAND THAT IF THE CHARGES FOR SERVICES RENDERED BY BOCA RATON PSYCHIATRIC GROUP, P.A. ARE NOT PAID WITHIN 60 DAYS OF THE DATES OF SERVICE, I AM OBLIGATED TO REIMBURSE BRPG THE FEES CHARGED BY ANY COLLECTION AGENCY, WHICH WILL BE ADDED TO THE ACCOUNT AT THE TIME ITS PLACED WITH THE AGENCY FOR COLLECTION: THIS MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 30% OF THE DEBT PLUS ALL REASONABLE COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES INCURRED IN SUCH COLLECTION EFFORTS. FURTHERMORE, I UNDERSTAND I WILL BE CHARGED INTEREST ON A MONTHLY BASIS AT A RATE OF 18% ANNUALY, UNTIL SUCH DEBT IS PAID IN FULL.

WE DO NOT CHARGE FOR PHONE CALLS REGARDING A QUICK QUESTION OR SIMPLE ISSUE, BUT CALLS LASTING OVER 3-5 MINUTES MAY INCUR A CHARGE SIMILAR TO AN OFFICE VISIT CHARGE.

I HAVE INFORMED BOCA RATON PSYCHIATRIC GROUP, P.A. AND ITS AGENTS OF MY INSURANCE COVERAGE OR LACK THEREOF. I UNDERSTAND THAT IF MY INSURANCE STATUS CHANGES (INCLUDING MEDICARE), IT IS MY RESPONSIBILITY TO INFORM BOCA RATON PSYCHIATRIC GROUP, P.A. AND THERE WILL BE NO REFUND, NULLIFICATION, OR REIMBURSEMENT OF THE FULL, NORMAL FEE PAID OR OWED TO BOCA RATON PSYCHIATRIC GROUP, PA. FOR SERVICES PROVIDED UP TO THE DATE OF NOTIFICATION.
I AM AWARE THAT ALL PSYCHIATRIC MEDICATIONS HAVE SOME ABILITY TO IMPAIR COORDINATION OR ALERTNESS AND I NEED TO CONSIDER THIS BEFORE I DRIVE OR OPERATE MACHINERY, THIS IS ESPECIALLY TRUE WHEN STARTING A NEW MEDICATION OR INCREASING A DOSE.

MUST FILL AREAS BELOW

SIGNED: _____
(IF GUARDIAN OR LEGAL REPRESENTATIVE, ALSO PRINT NAME)

PATIENT'S NAME: _____
DATED: _____