



POLICIES AND PROCEDURES

Clients must complete and sign this form prior to your first appointment. Office fees will be highlighted. These policies and procedures will establish the expectations you will receive from **AJ Psychiatry, PLLC** and also what is expected from you as the client.

1. **APPOINTMENTS:** Please arrive at your appointment time.
 - **Late arrival** of 15 minutes or greater for any appointment may need to be rescheduled. If the appointment must be rescheduled, then the appointment is considered missed without cancellation \$75.00 for the appointment.
 - **Rescheduling appointments:** To cancel your appointment please give at least a 24-hour notice. If you need to reschedule, call the office.
2. **MISSED APPOINTMENT:** If you have not cancelled your appointment in advance, you (not your insurance company), will be billed \$75.00 for the appointment.
3. **MEDICATION REFILLS AND OTHER CLINICAL NEEDS:** If you have a life threatening or emergent need please go to your nearest emergency room or call 911.
 - **If you have a clinical/medication need** please call the office (214-744-5438) and follow the prompts to leave a brief message. Most calls left during business days (Monday-Thursday) are returned by the next business day. Non-urgent calls left on Friday, Saturday or Sunday will be returned on Monday.
 - **Prescription Refills:** During office appointments clients are given enough medication until their next appointment. Therefore, refill requests outside of office appointments are subject to a \$15.00 fee. Please note **NO REFILLS** will be issued to controlled substances and stimulants. All lost stimulants and controlled substance prescriptions will require a police report before a new one is issued.
 - **No Text Messages:** Please note that text messages are not accepted and will be deleted upon receipt.

- **Email Response:** Emails are addressed as time permits therefore it is recommended you call the office for any needs.
4. **LABORATORY SERVICES:** Clients on controlled substances (narcotics and stimulants) are expected to honor their blood work appointments as scheduled. **FAILURE TO HONOR** their blood work appointments would be considered interruption of services. **NO MEDICATION WILL BE REFILLED until such appointments are honored** and results are available for review.
5. **INSURANCE:** A current insurance card must be presented at the first visit and when your insurance has changed. If not, you will be responsible for the self-pay rate of the appointment.
- If AJ Psychiatry PLLC is not contracted with your insurance carrier or your visit is a non-covered service, you are responsible for the charges.
6. **CREDIT CARDS:**
- If you choose to pay with a credit card the information will be stored in a secure vault within our electronic health record and considered on file.
 - **I hereby authorize AJ Psychiatry PLLC, to charge the credit card on file for balances more than 30 days in arrears. This includes payments for missed appointments and fees not reimbursed or covered by insurance.**
7. **PAST DUE ACCOUNTS:**
- Any remaining balance after insurance has been filed is your responsibility.
 - You will receive two bills from AJ Psychiatry, PLLC. If you have not paid in full within 60 days your account will be turned over to a collection agency. If your account is sent to a collection attorney, they will report your past due status to a Credit Reporting Agency and you will be responsible for their fees.
 - I agree that AJ Psychiatry PLLC may contact me by telephone, electronic messages, mail or cell phone as provided by me or person on my behalf or that are identified as mine at a later date. I understand that these communications may be from this provider and/or those providing services within the facilities of, or on behalf of, this I provider including communications about the scheduling, treatment or payment for services rendered. These calls include but are not limited to using an automatic telephone dialing system, artificial or prerecorded voice or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service ("Authorized Communications"). I understand that my agreement



to the terms of the Patient Consent and Assignment of Insurance Benefits is not a condition of willingness to provide treatment to me. I consent to any and all of the authorized communication methods even if I will incur a fee or a cost to receive such communications. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the relevant entity.

8. **COMPLETION OF FORMS:** A fee is charged for the completion of forms including the following but not limited to: FMLA, and Leave of Absence, also letters regarding flying and or airline tickets, coverage of medications and letters to employers. The client will always be notified of any charges upfront and payment may be requested prior to the release of the requested forms. AJ Psychiatry will NOT do Disability paperwork.

This is an agreement between you (the client or responsible party of the client) and AJ Psychiatry PLLC. By signing this agreement, you agree to abide by all the policies and procedures stated within.

Date: ____/____/____ Client's Name: _____

Signature of Client or Responsible Party: _____