Poehailos, Dupont & Associates, PLC

887B Rio East Court
Charlottesville, Va 22901

Phone 434.220.4686 Fax 434.220.4687 www.pdakids.com

Contract for Psychiatric Evaluation

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Patient:_____ Financially responsible party: _____ Date:_____

Please **initial** next to each item

_____I am agreeing to psychiatric assessment for me/my child with Poehailos, Dupont, & Associates, PLC.

_____ I understand that my insurance company may cover some but not all of the evaluations administered as part of this assessment and that I am financially responsible for all remaining charges.

_____ I understand that there may be additional fees related to coordination of care, consultation (including phone calls and meetings), record review, and educational planning/providing resources, that are not covered by my insurance and will be priced at the hourly fee of $250/hour. I understand I will be billed as these services are rendered.

_____I understand that the psychiatric evaluation may take up to three sessions before a treatment plan or medication recommendations are provided to me.

_____ I understand that there may be co-payments, co-insurance, and deductible costs based on my insurance plan that are direct charges to me.

_____ I understand that the initial intake session and any follow up interviews or feedback related appointments will be billed as therapy appointments and charged to me based on my mental health insurance coverage.

_____ I understand that should I call to cancel an assessment appointment with less than 24 hours notice, or no-show for an appointment, I will be charged in full for the session. Assessment is billed by the hour and the fee is $250 per hour. A missed appointment is not billable to insurance and my credit card on file will be processed for the full amount.

By signing below, I acknowledge that I have read and understood the previous statements and agree to move forward with the assessment process.

_____

Signature Date