

CONSENT TO TREAT AND OTHER OFFICE POLICIES

Patient Name: _____ Date of Birth: _____

CONSENT TO TREAT: By signing this form, I consent to treatment by my primary Surya Psychiatric Clinic, PLLC (SPC) physician, Dr. Tejas Patel, and/or their assistant(s). I am aware that if my primary SPC doctor is unavailable, I will get a phone call back for urgent issues providing coverage for the SPC physician.

_____ Initials

FOR PATIENTS WITH INSURANCE:

- Initial deposits become refundable after claims are processed by patient's insurance carrier(s). As insurance companies operate on their own timeline, Surya Psychiatric Clinic, PLLC cannot speak to the timeline. However, if claims are paid in full; the finance department will initiate a prompt refund of 75 dollars.
 - When refund is not applicable:
 - Patient has co-payment, coinsurance, or deductibles as set forth by their insurance carrier.
 - Patient fails to provide ample notice of cancellation (48 hours) or late arrival
 - In such instances, Surya Psychiatric Clinic, PLLC will apply the patient's deposit to the open account
- It is my responsibility to contact Surya Psychiatric Clinic's billing department regarding any questions about my account. I, hereby, state that I will not dispute the initial deposit charge as I gave verbal consent to Surya Psychiatric Clinic, PLLC while scheduling my appointment.
- We bill select primary insurance carriers for you if proper paperwork is provided to us. If your insurance requires a referral or prior authorization it is your responsibility to assure that one is available to our office prior to or at the time of your service.
- Our office contract with select insurance carriers, please contact your insurance prior to your appointment to verify you are receiving care from a participating provider.
- Co-payments, coinsurance, and deductibles are due at the time of service. If you are unprepared to pay these charges on the day of your visit, immediate payment plan needs to be instituted with office staff and needs to be followed strictly.
- Since your agreement with your insurance carrier is a private contract between you and your carrier, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If you have questions about your benefits or your insurance carriers' decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

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MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All coinsurance amounts or deductibles not covered by an insurance plan are due and payable at the time service is rendered.

_____ Initials



Tejas B. Patel, MD, MBA
Surya Psychiatric Clinic, PLLC
Phone: 520-639-8576

6650 N Oracle Road, Ste 110
Tucson, AZ 85704-5604
Fax: 520-639-8635

FOR PATIENTS WITHOUT INSURANCE: Provider's fees vary depending upon the type and length of service. Session time may include interviewing, therapy, planning, reports, dictations, related telephone conversations, and any other time spent concerning patient care. Provider will determine what length of session to schedule based on clinical needs. Many insurance plans have preset fees which are not affected by these rates. Please discuss any concerns with your provider. These charges are due at the time of service.

Following is current self-pay fee schedule:

- Initial Evaluation : \$400
- Follow-up Sessions up to 20 minutes: \$150
- Follow-up Sessions up to 21-40 minutes: \$300
- Follow-up Sessions up to 41-60 minutes: \$450

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NONCOVERED SERVICES: It is your responsibility, as the insured member, to know what your insurance policy covers. Any care not paid for your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

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COLLECTION OF FEES:

- If I fail to make payment when due and the account become delinquent or is turned over to a collection agency or an attorney of collection, I/We agree to pay all collection fees equating up to 50% of the outstanding balance at the time the account is placed for collection services.
- If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above cost.
- We reserve the right to terminate the patient-clinician relationship for accounts that are past due after 60 days.
- Outstanding balances, over 60 days, will accrue 1.5 percent interest every month.
- There will be a \$35/- fee for returned (NSF) checks after which future payments must be cash, ATM, or credit card only.

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**SURYA PSYCHIATRIC
CLINIC**

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APPOINTMENTS:

- Appointment time is agreed to be specifically reserved for you. Initial visits are 60 minutes, and follow-ups vary from 10-30 minutes. All efforts are made to see you at the appointed time, but if emergent circumstances (as determined by the provider) cause delays, you will still receive your full appointment duration if you stay in the office. But if you don't wait a reasonable period of time, you may be charged \$100/- for a missed appointment.
- To cancel or change appointments, you must call 2 business days BEFORE the day of your scheduled appointment. Cancellation or appointment changes without 2 business day notice, or missed appointment will result in you being charged a fee of \$100/-. You will be responsible for prompt payment of this and any other outstanding charges before your next appointment.
- You should not leave our office after a session without first setting another appointment, and you should ask for an appointment reminder card.
- We attempt to confirm all appointments, but this is only a courtesy to you and not a guarantee that we will call. Please do not rely on our call as your only method of tracking appointments. You are responsible for keeping appointments, even if we don't confirm the appointments.
- Two (2) or more late cancels or missed appointments, or excessive appointment changes may result in treatment termination.
- Please notify us promptly if you plan to end treatment in our office. If more than six (6) months passes without phone contact or an appointment, the doctor-patient relationship will be considered voluntarily ended by you, and you must call the office to arrange for re-evaluation appointment if you wish to continue care at SPC.

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TELEPHONE CALLS:

- In the event of a life-threatening emergency, such as suicidal or homicidal ideations, please call 911 or go to the nearest ER.
- If you're having a psychiatric crisis but NOT life-threatening, please call community-wide crisis line at 520-622-6000 or 866-495-6735.
- Call during normal business office hours (Monday thru Friday 9am to 5pm) for prescription refill, to schedule or cancel an appointment or any routine services.
- Please call Dr. Tejas Patel at 520-512-5367 **after normal business** hours for urgent situations (such as severe side effects, medications reactions, suspected pregnancy, or any serious issue) which cannot wait until the next business day, and he will be called by answering service to return the call. Keep leaving messages if you aren't called back in 15 minutes. Please note that major medications changes and therapy cannot be done by phone. Again, in the event of a life-threatening emergency, such as suicidal or homicidal ideations, do not call this number but please call 911 or go to the nearest ER.
- You may be charged \$25 for each instance if you call after business hour phone number for routine services, such as requesting refills, cancel or change appointment times, etc.
- If Dr. T. Patel is not available, covering provider will return urgent calls.



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- During normal business hours, clinical staff is not available to immediately respond to each telephone call. Please inform the front desk person if the call is urgent and it will be returned at clinical staff's earliest availability.
- Routine phone calls during business hours are usually returned the same evening but it may take up to 24 hours to return the call.
- You may be charged \$25 for each instance of extended or excessive non-emergency phone calls or prescription refills outside regular appointments, which are not usually covered by insurance and are solely your responsibility. Be sure to get your prescription at each office visit. What is considered extended or excessive non-emergency phone calls is up to the provider but some examples include following:
 1. More than two (2) phone calls per month unless instructed by the provider to call in for clinical reasons or calling in for reasonable clinical issues, such as worsening of the condition, serious adverse events due to medications, etc.
 2. Phone calls lasting longer than Five (5) minutes except for reasons mentioned above.

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PRESCRIPTIONS AND REFILLS:

- Prescriptions are written or electronically transmitted by the provider at the time of your visit with sufficient quantities and refills (if applicable) to last until your next appointment. Please notify your pharmacy or the office should you run out of medication prior to your next appointment.
- It is your responsibility to get your prescription at each office visit. Please provide your pharmacy name, phone and fax numbers to the staff at first visit and when you change your pharmacy.
- Patients on controlled substance medications should use the same pharmacy each time for refills. Patient may be required to sign a controlled substance agreement with the office.
- Requests for routine medications will usually be called in or transmitted to pharmacy typically on the same day but it may take up to 2 business days in some cases.
- Request for schedule II medications (such as Adderall, Ritalin, Vyvance, etc.) must be requested at least 3 business days in advance.

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PATIENT ASSISTANCE AND SAMPLE MEDICATIONS:

- You must give this office a 1 business day notice that you are in need of sample medications.
- At the time of your call we can advise you whether we have samples available of your particular medications. Note that our sample supply is very limited.
- If you need help with Patient assistance medication through pharmaceutical company, you need to speak with the staff and set up appointment. It may take 5-7 business days after your appointment to have our portion of patient assistance medication paperwork done.

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REQUESTED CORRESPONDENCE, FORM COMPLETIONS, AND MISCELLANEOUS REQUESTS:



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- This includes, but is not limited to, letters to companies or organizations, and form to be completed by SPC staff or Dr. Tejas Patel (i.e. guardianship papers, medical source statements, FMLA forms, statements to return to work etc.).
- We charge \$50 per form/letter (including those needing only signature) as we cannot bill your insurance company for these charges.
- You will be responsible for paying these fees and the assessed fee must be paid before the correspondence is sent.
- When necessary, a valid release of information must be provided with each request.
- We require minimum of two (2) business days and a maximum of fourteen (14) business days to respond to your request.

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AUTHORIZATION

I authorize use of this form on all my insurance claim submission.

I authorize the release of any medical, mental illness, substance abuse, or other information necessary to process my insurance claims.

I understand that **I am responsible** for my bill, even in the event that services are not authorized by my insurance company.

I authorize **Tejaskumar B. Patel, MD** to act as my agent in helping obtain payment from my insurance carrier/s.

I irrevocably authorize payment of medical benefits directly to **Tejaskumar B. Patel, MD**. For services rendered to me.

I request payment of government benefits be made directly to **Tejaskumar B. Patel, MD.**, who hereby accepts such assignment.

I permit a copy or fax of this authorization to be used in place of the original.

I also acknowledge that assignment of benefits to CarePlus does not relieve me of the responsibility of payment for disallowed services, co-payments, and deductibles associated with the provided services to the extent allowable by law.

I have read, fully understand, and agree to the above terms and information.

Signature of Patient/Legal guardian

Patient Name (PRINTED)

Date



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