Piedmont Psychiatric Clinic
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Adult, Adolescent, Family and Administrative Psychiatry

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Dear Patient/Guarantor:

Please review the following policy and initial beside each one. Please feel free to discuss with your provider.

1. _____**Due to Health Information Portability Account Act:** We will require each patient to schedule or cancel their own appointments with the exception of minors. This will help our office ensure that we keep you and your information with our office as private as possible.

2. _____**Medications:** Please remember to bring all of your medications prescribed by our office and all other physicians as well so that we will be able to give you the best care possible. It is important to us to know if you are taking other medications that may have an impact or interaction. Please remember to give us two business days to call in prescription refills.

3. _____**Medication Refills:** Our office will not call in routine prescription medication after hours, weekend or holidays. Please note there is a fee for calling in prescription(s) the first prescription is $25 and each prescription there after during that same telephone call to the pharmacy will be $10. *Please remember that you as a patient will need to call our office to request the refills. We will not refill pharmacy requests. Please allow 48 hours (2 business days) for our office to refill your medications.

4. _____**Cancellations:** All cancellations must be made by the patient during office hours Monday through Friday 9:00 AM to 3:00 PM. (please read the full office policy and procedures that you were given during your original appointment for more details) If for any reason you may need to cancel or reschedule your appointment, please do so at least 48 hours (2 business days) prior to your scheduled appointment so that you will not be billed the full fee. We will charge the full fee to your credit card on file for missed or late cancelled appointments. These can not be billed to your insurance. (*full fee means full office charge not just your coinsurance payment.) *Please note that we do not accept cancellations left on our voicemail or by facsimile.

5. _____**Payments:** You will be responsible for your co-pay at the time of service, plus any unpaid balance on the account once your insurance has paid its portion. (In the event that we are contracted with your insurance plan). All payments and co-insurance payments are due at the time of service. **A twenty-five dollar billing fee will be charged for failure to pay the balance / your co-insurance payment at the time of service.**

I had reviewed the above items with my provider and had the opportunity to have my questions answered. I understand these are bullet points to help remind me of the Piedmont Psychiatric Clinics policies and procedures that I had originally signed upon my initial office visit.

Patient's Name: (print)_____

Patient's Signature: _____ Date: _____

Provider's Signature: _____Date: _____