Columbus Psychiatry

I, _____ acknowledge that I am responsible for the payment of services for _____ to Columbus Psychiatry at time of service.

Payment can be made by Cash, Check, or Major Credit card. There is a 2.7% service fee for credit card. There will be a $30 fee for returned checks.

Columbus Psychiatry is not a participating provider on any health insurance plan, nor does Columbus Psychiatry file health insurance claims. A receipt will be provided, upon request, at the end of the visit for submission for out-of-network claims.

Fee Schedule is as follows:

Initial Psychiatric Evaluation (up to 60 minutes)	$400
Individual Psychotherapy and medication management (up to 60 minutes)	$400
Individual Psychotherapy and medication management (up to 30 minutes)	$240
Medication Management (up to 15 minutes)	$175
Form Completion (some forms may require an appointment)	$35 Processing Fee plus $5 per page
Other Services (greater than 60 minutes)	$TBD at time of visit

No Show/Cancellation Policy:

All cancellations must be made within 24 hours of appointment. Any cancellations made less than 24 hours prior to a patient's appointment will be considered a No Show. All No Shows will be billed at full fee and will be due prior to the patient's next appointment.

Office Termination Procedures:

Columbus Psychiatry maintains the right to terminate patients from the office if there have been 3 consecutive no shows or late cancellations. The family will be provided at time of termination enough medication to last 3 months, if required and able to do so. Additionally, a list of alternate providers will be provided the patient to contact on their own for follow up.

Fee schedule will expire 12 months from date of signature and is subject to change at anytime, unless otherwise specified.

Your signature below indicates that you acknowledge the information listed above.

Guardian Signature:_____ Date: _____