

Psychiatrist-Patient Services Agreement

SERVICES AND FEES

As treatment needs vary for different people, Dr. Foster will work with you to set up the most appropriate schedule. Payment is expected at the end of each session.

Fees are as follows:

One and a half hour Intake session: \$520

One hour follow up for med check/therapy: \$420

Half hour for med check: \$220

If these rates were to change, you will be notified at least 30 days before the next charge.

If a patient's payment is not completed, a fee of \$10 will be added to the cost of the session.

Dr. Foster currently has in-person office hours Tuesday through Thursday, 10am through 5pm. She is available for scheduling and quick phone calls between 8am and 6pm Monday through Friday. If your call is missed, or is placed outside of those hours, please leave a detailed message and Dr. Foster will respond within one business day. Long and detailed phone conversations will be billed at the same rate as an in-person session.

In the event of an unforeseen and complex situation, Dr. Foster will schedule a patient for an in-person or telehealth session as quickly as possible. Appointments scheduled outside of regular office hours will require an additional fee.

Written reports, professional consultations, treatment summaries, or any other services on behalf of the patient will be prorated at the usual hourly rate.

INSURANCE REIMBURSEMENT

Dr. Foster does not accept medical insurance. She is considered an out-of-network provider. The patient is responsible for all correspondence with the insurance company to obtain reimbursement. The patient is responsible for all charges incurred for any treatment.

COMMUNICATION

In-person sessions are limited to Tuesday through Thursday, 10am to 5 pm.

Phone messages and phone calls will be answered Monday through Friday, 8am to 6pm. If Dr. Foster is in a session when your communication is received, it will be answered at her next opportunity, the same business day.

If you reach Dr. Foster's voicemail, please leave a detailed message, and she will respond to you within communication hours that same day.

EMERGENCIES

In the event of an life-threatening emergency, please call 911, the Suicide Hotline at 988, or go to the nearest Emergency Room.

CANCELLATION AND MISSED APPOINTMENTS

If you need to cancel an appointment, you must cancel at least 24 hours in advance. If an appointment is not canceled within 24 hours in advance, there will be a charge at the regular rate.

Please schedule the appropriate amount of time for your needs. Additional time can not be granted after the appointment has been scheduled. In the event that additional time is absolutely necessary, the patient will be charged for any additional time required. If you are more than 10 minutes late for your appointment, it will automatically be canceled and you will be billed accordingly. In the event of two missed appointments within one calendar year, you will be discharged from the practice. Upon your discharge, you will be referred to another clinician.

PRESCRIPTION REFILLS

Prescription refills will be handled during the appointment. If a non-emergency prescription is filled outside of regular hours, a fee of \$20 will be billed. Emergency prescriptions called in after hours will be billed at the rate of a usual session.

CONTROLLED MEDICATIONS

Controlled medications are controlled by both federal and state regulations. Because of this, please heed the following guidelines.

- Prescriptions for controlled medications can be obtained during in-person appointment only
- Prescription medications can be written for a maximum of 90 days
- It is the patient's responsibility to schedule follow up appointments within their 90 day supply
- Refills will not be granted over the phone, and lapses in taking controlled medications may require an emergency room visit.
- Lost prescriptions can not be replaced.
- Ensure your prescription has been correctly filled at the pharmacy
- In case of abuse of a medication, the medication will be discontinued and alternatives may be discussed.
- Egregious misuse or abuse of controlled medication will result in discharge from the practice.

MAINTENANCE MEDICATIONS

Follow up appointments will be scheduled at Dr. Foster's discretion, based on multiple factors which will be discussed in person. Prescription refills will be written for the period in between appointments. It is the patient's responsibility to schedule all follow up appointments which must occur 2 weeks before the prescription runs out. Refills will not be authorized without follow up appointments. Many insurers are requiring 90 day supplies, thus if appropriate, a 90 day prescription will be authorized. Refills will only be filled if recommended follow up appointments are kept.

CONFIDENTIALITY

All information related to your care is kept strictly confidential.

No information will be provided to third parties without the patient's written consent except if required by law. These legal requirements may include potential harm to yourself or others, possible child abuse and court subpoenas. Medical exceptions can include communication with other medical professionals, hospitals, labs and your insurance company.

LEGAL ISSUES

Dr. Foster can not provide work excuses, disability determinations, nor does she advocate for her patients in lawsuits, custody disputes or work grievances.

TREATMENT MAINTENANCE

Dr. Foster has the responsibility to maintain the doctor-patient relationship with the cooperation of her patients. In order to do so, Dr. Foster will evaluate and treat patient symptoms with the appropriate measures. The patient's responsibility is to follow Dr. Foster's professional opinion including medication regimen, any referrals to other practitioners or lab testing and EKG. The patient is responsible for the continued adherence to his or her medication regimen, as well as transparency about any symptoms they experience, and current/prior medication as well as drug and alcohol use. If there is continued disregard for the doctor-patient relationship by the patient, he or she may be discharged from the practice with a 30 day notice.

Your signature indicates that you have read and understood all the information put forth in this document and agree to follow all policies listed. Any questions or concerns can be directed to Dr. Foster at the provided contact information.

Signature _____

Name _____

Date _____