Asa G. Yancey, Jr., M.D., P.C.
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Board Certified in Adult Psychiatry,
and Child and Adolescent Psychiatry

Contract and Consent for Evaluation/Treatment

In consideration for receiving treatment and/or medication/psychiatric services, I/we agree to the following:

FEE PAYMENT

Dr. Yancey sees patients on a fee-for-service basis only. The patient or parent is responsible for full payment at the time of service. Dr. Yancey's charge is $350 per 50 minute session and $175 per 25 minute session. **Payment is due at the time of service.** Returned checks will be assessed a fee of $50.

If payment is not made at the time of service, a $20 billing charge/late fee will be assessed. ***Bills can only be sent to one address per patient.*** The patient/parent must pay all fees and bill within 10 days of receipt. If payment is not received, the account may be turned over to a collection agency within 30 days. Dr. Yancey has the option to pursue all lawful collection procedures available, and the patient will be responsible for all costs of collection, including all attorney fees. The minimum collection fee will be 50% of the account balance. Unwillingness to pay may result in termination of services.

You may use credit card, cash or check for payment. Please write the credit card and expiration date in the space provided and sign below. If payments are more than two weeks overdue from the date of service, you agree to have us bill your credit card.

CANCELLATIONS

APPOINTMENTS MADE AND NOT KEPT ARE FULLY BILLED TO YOU. YOUR INSURANCE COMPANY WILL NOT REIMBURSE FOR ANY PORTION OF MISSED APPOINTMENTS. CANCELLATION NOTIFICATION MUST BE GIVEN AT LEAST 24 HOURS BEFORE YOUR APPOINTMENT. The fee is the same as for the missed session. Every attempt will be made to place a reminder call, or e-mail to you before each appointment. You are ultimately responsible for keeping appointments or cancelling with at least 24 hours notice or noon Friday for Monday appointments.

INSURANCE

Many insurance plans reimburse for some portion of psychotherapy and medical pharmacotherapy. ***Please direct questions about reimbursement amounts and timeliness of payments to your insurance company before arriving for services.*** Dr. Yancey is not contracted with ***any*** insurer. We will provide you with a superbill at your appointment that you may submit to your insurance company if you choose. Please not that we do not complete any insurance paperwork.

RECORDS

Record requests are received from patients/parents and other sources. These requests will only be executed if the patient/parent completes a signed Release of Information. Records are copied at $0.20 per page plus postage and billed directly to you. Please allow two weeks for this request to be processed. ***AUDIO OR VIDEO RECORDING OF SESSIONS ARE STRICTLY FORBIDDEN.*** This will result in immediate patient termination.

LETTERS

Requested letters are to be sent to schools, employers are a minimum $25 charge.

COURT/LEGAL FEES

MY PREFERENCE IS TO NOT APPEAR IN COURT. If there is a situation that requires my court appearance you will be charged a minimum $3,000 for half-day and $5,000 for full day. A subpoena means you have agreed to these court costs. I require one months notice to prepare and make schedule arrangements. Please note you will be responsible for *ANY* attorney's fees.

TELEPHONE CALLS

These are welcome within limits and less than 5 minutes long. My assistant and I will respond to these within a reasonable time. There is no charge for calls less than 5 minutes long. Calls lasting longer than 5 minutes will be charged to you on a prorated basis, minimum $25. If you have an extreme emergency, please call 911 or 303 869 1999.

OTHER MEANS OF COMMUNICATION

Text messaging is never utilized. ***E-Mail is utilized to assist scheduling. Clinical questions will not be addressed via e-mail.*** Clinical questions are addressed by appointments and minor questions via telephone. Voice mail is checked throughout the regular business day by my assistant in a timely manner. Dr. Yancey's routine call backs are at the end of the business day. Calls received on weekends or holidays are returned the following business day. Emergent clinical calls are addressed by cell phone. ***Refills will not be filled on weekends or holidays.***

PLEASE NOTE THAT PRACTICE STANDARDS REQUIRE ALL PATIENTS BE SEEN AT LEAST EVERY THREE MONTHS

I HAVE BEEN INFORMED OF AND READ THE PRECEDING INFORMATION AND AGREE TO IT.

_____ _____
Patient name Guarantor for Payment (Please Print) & Guarantor Signature

_____ _____
Relationship to patient (Self, Parent, Guardian, Other) Date of Signature