Anita Red, MD
Adult, Adolescent, & Child Psychiatrists

The Office of Dr. Anita Red

Billing Policies and Financial Agreement

Thank you for considering and trusting your psychiatric care to me. I realize that choosing a psychiatrist is a very important decision, which is influenced by many factors. Please take a moment to review the information below. Do not hesitate to contact me if you have any additional questions.

Billing Information:

1. Telephone calls and calls to the patient's parents or collateral information sources (outside therapists, schools, etc.) calls are billed at a 25 minute rate.
2. Cancellations and missed appointments must be made within two business days, or the patient will be billed at the rate for the full time allotted.
3. If you have insurance, you will be provided with an insurance statement that you may submit to your insurance company. I am not a contracted provider with insurance companies, Medicare, or Medi-Cal.
4. Payment is expected at each session unless other arrangements are made in advance.
5. Payment may be made by credit card, cash, or checks. Checks will be made payable to "Anita Red, M.D."
6. If you are more than 10 minutes late to an appointment, you will be asked to reschedule your appointment for another time.
7. Fee Schedule
    - Initial evaluation, 90 minutes – $1,200
    - Second follow up evaluation, 50 minutes - $800
    - Follow up visits, 25 minutes – $600
    - Follow up visits, 50 minutes - $1,200
    - Telephone calls, letters, or reports - $600

I consent to care and treatment by Anita Red, M.D. and associated physicians, healthcare providers, and other staff members in accordance with their professional judgment. I understand that my treatment and care may include psychiatric services as well as other routine care or well patient care.

Financial Agreements

I understand that I am financially responsible for all charges for services rendered by Anita Red, M.D. according to the terms stated above, including but not limited to, office visits, cancelation and missed appointments, telephone calls, preparation of reports, and late fees. This agreement is for the entire course of the treatment for the patient.

Payment Agreement

I authorized Anita Red, M.D., to charge my credit card in the event that I (or the party for whom I am financially responsible for) fail to show for a scheduled appointment, or do not notify my provider at least 2 business days in advance for a cancelled appointment. Furthermore, for outstanding payments of services rendered, I authorize charges to my credit card for the full amount due. I agree to not dispute charges for any of these reasons and understand that clinical information will need to be released if a dispute is initiated. I further authorize my provider, Anita

Red, M.D., to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in a clinical file and may be updated upon request at any time.

Please note: Your credit card will not be charged unless one of the following conditions applies:

1. no-show for a scheduled appointment.
2. cancellations less than 2 business days in advance.
3. participation in treatment (i.e. appointment or phone session) without payment rendered.

_____ _____

Patient's or Patient Rep Signature Date

_____

Print Name