Agreement with Peaceful Mind Psychiatry

I, _____, hereby consent to evaluation and/or treatment of myself rendered by Dr. Jing Liu. I will arrive at the office before or at my appointment time. I understand that I am responsible for the appointments I have scheduled. I will reschedule or cancel my appointment at least one business day prior to my appointment time instead of waiting for the courtesy reminder to cancel, which may result in a late cancellation fee. **I agree to pay the full fee at the self-pay rate if my appointment cancellation is made less than one business day or I fail to show up.** I understand that this is necessary because a time commitment is designated and committed exclusively for me. Thus, if I am late for an appointment, I may lose some of that appointment time. I understand I may not be seen if I am more than ten minutes late to my appointment, which will also result in a late cancelation fee.

I consent that my credit card be kept on file and used for co-payments at each visit, late cancellation or no-show fees, or any past due payments without my presence. If I do not have a credit card, I will make a deposit of $175 by check or cash, which will be returned at the termination of our patient-physician relationship. I understand a $25 service fee will be charged for any checks returned for any reason to cover bank charges.

If I file my own insurance or do not have insurance, I will pay the full fee ($300.00 for the initial evaluation and $175 for follow up appointments) on the day that services are rendered.

If I have an insurance policy, I authorize the release of any medical records or other information necessary to process the claims for my visits. However, I understand that the contract is between me and my insurance company and I am fully responsible for any amount not paid by my insurance. I will submit to the office my co-payment on THE DAY OF MY SESSION. I understand there are additional charges if sessions continue beyond the scheduled time or if phone calls extend beyond 5 minutes.

If I develop an outstanding balance, I will pay the charges within 30 days or create a payment plan. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Bills left unpaid upon final notice will be send to a collection agency. Any reasonable attorney fees and costs incurred by the office for the collection of the past due account shall be my obligation as well.

If I miss three follow-up appointments or fail to schedule an appointment in 6 months, for legal and ethical reasons, the physician-patient relationship will be terminated automatically, and I will no longer be a patient at Peaceful Mind Psychiatry.

I acknowledge email communication is not secure and will only use it for non-private information. I will use practice fusion messages or phone calls for private communication.

I understand and agree with all the above office policies.

Signature_____ Date _____