Basheer Lotfi-Fard, MD
Child, Adolescent & Adult Psychiatry
500 W Wilson Bridge Road, Suite 240
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Summary of Practice and Policies

APPOINTMENTS AND FEES:

Initial Psychiatric Evaluation (60 min):	$425
Follow up Appointment (45 min):	$250
Follow up Appointment (25 min):	$175

Payment for service is expected at the end of each session, either cash or check. I do not accept credit card, nor am I participating in any health insurance plan. However, a receipt can be provided at the end of the session to submit for out of network claims. Additional charges may also occur for contact outside of a scheduled appointment that requires more than a brief amount of time. A returned check fee of $25.00 will also be charged for all dishonored checks.

CANCELLATIONS AND NO-SHOWS:

"No Show" appointments and cancellations with less than 24 hour notice will be billed to you at the full fee. Your insurance company will not reimburse you for this. Exceptions to the 24 hour notice policy would include a specified emergency or if the appointment can be filled in your absence, but still subject to 50% of the full fee.

CONFIDENTIALITY:

Everything that takes place in treatment is confidential and will not be released without your expressed written permission and consent.
There are two exceptions to this: if you or your child becomes a danger to self or others; and if you or your child is involved in child abuse. In these situations, I am legally bound to break confidentiality in order to protect all involved.

EMERGENCIES AND AFTER HOURS:

My voicemail will be checked frequently throughout the day and at least once on weekends. I will return your call as soon as possible. You are also welcome to leave a voicemail. In the event of an emergency, please call 911 or go to your nearest emergency department.

I consent to psychiatric medical care provided by Dr. Lotfi-Fard. I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is more than 60 days in arrears, I authorize that pertinent billing information can be released to a professional service for purpose of collection of the outstanding balances.

Signature (Patient/Guardian): _____ Date: _____