Max Psychiatry

1011 W. Williams Street, Suite 106, Apex, NC, 27502
Phone:(919) 386-0402; Fax:(919) 882-0931

Outpatient Service Contract

Thank you for choosing Max Psychiatry for your mental health needs. Please take a moment to familiarize yourself with our policies and procedures and do not hesitate in contacting us if you have any questions.

Appointment Cancellation

- Appointments not cancelled or rescheduled at least 24 hours in advance will result in No-Show / late-cancelation fee of $50.
- Two or more missed appointments with late or no cancelation may result in termination of your care from the practice.

Payment responsibility

- All co-payments and/or deductibles are due at the time of service.
- Max Psychiatry will file your claim as a courtesy with an understanding that if insurance doesn't make payment within 90 days then the bill is the patient's responsibility. Past 90 days your account may be placed in the hands of collection agency. You will be responsible for all charges associated with collection efforts such as Collection agency fee, interests, attorney cost and court costs. The collection fees are calculated as 65% of the past due balance.
- If you do not have a copy or your current insurance card or have no insurance, the payment is due at the time of service.
- If Max Psychiatry is not contracted with your insurance carrier then you are responsible for the full payment at the time of service.
- The services such as medical records, reports, form-completion, verbal and/or written correspondence will be charged a minimum of $25 and not to exceed $100.

Prescription Refills

All prescription refill requests must be made during regular business hours. Please allow three business days to process these requests and DO NOT WAIT UNITIL YOUR MEDICINES RUN OUT. We reserve right to charge $20 fee for any prescription refill request resulting from missed or cancelled appointments.

Consent for Treatment

If you are 18 years of age or older you are personally consenting to the treatment. If the patient is other than yourself and you are the legal guardian/parent, you are consenting to the treatment for the patient.

Please note that your first visit is a psychiatric assessment with the provider. During this assessment the provider will evaluate if they can provide appropriate service to best meet your mental health needs. If, for any reason, our providers feel that they are not able adequately address your health care needs then appropriate referrals will be made.

By signing below you are acknowledging that you have received, reviewed, understood, and agreed to the "Notice of privacy practices of Max Psychiatry" and "Max Psychiatry out Patient Service Contract". These documents describe the practice's, policies and procedures related to the use and disclosure of any component of your protected health information created, received and maintained by our practice and the practice's policies and procedures regarding filing insurances, understanding your benefits and acknowledging the fees associated with the No-Shows forms and letters.

Acknowledged and agreed by:

_____ _____

Patient's Name Date

_____

Patient's Signature

_____

Parent / Guardian's Name