Premium Psychiatry Service of Central Jersey, LLC

Patient- Physician Payment Agreements:

Patient name: ____ DOB: ____________

Financial Responsibility: I understand that Dr Desai is not in-network with any insurance, including Medicare and Medicaid plans, and I am aware that I will be responsible for the patient's fees to Dr. Ankur Desai. These charges include, but are not limited to, any fees incurred due to unpaid balances, reasonable collection and court costs will be paid by the undersigned; any balances outstanding after 90 days will be submitted for collection. I am responsible for fees resulting from appointments not kept or cancelled without a 24 hour notice. I understand that the services must be paid at the time services rendered, and I am responsible for filing for the insurance reimbursement. I understand that if the case is submitted for collection only the demographic information and payment information will be share with the collection agency.

Rates: Evaluation: $500.00. For follow up appointments up to 30 minutes $200.00. If the follow up appointment lasts longer than 30 minutes, but less than an hour, the fee will be $250.00. Cancellation fee is $75.00. Any returned payment will be charged additional $35.00.

Please see the Fee Schedule/ Good Faith Estimate for a full list of possible fees.

____ ____________________

Patient/ Parent signature Date

____ ____________________

Responsible party's signature Relation to patient

Third party payment: I understand that the following is the agreement between Dr. Ankur Desai and ____

I am responsible for charges incurred due to any missed session. I am aware of the charges that I would be responsible for, after the third party contract is completed.

____ ____________________

Patient/ Parent signature Date

____ ____________________

Responsible party's signature Relation to patient