Maurie Mintz, M.D., L.L.C
1784-A Century Blvd.
Atlanta, GA 30345
404-795-2097

Patient Services Agreement

I am committed to providing professional services of the highest quality. In order to serve you as responsibly and efficiently as possible, it is important for you to understand the policies of my practice. Before you begin or continue treatment with me, I require a signature indicating understanding and acceptance regarding the policies of my practice. Please discuss any concerns or questions with me before signing this agreement.

Scheduling: My private practice office hours are Tuesday and Thursday 9:00 am to 2:30 pm. Appointments may be scheduled by calling and leaving a message regarding the days and times most convenient for you. Please be sure to indicate in your message whether I may leave a message for you on your voice mail with respect to a potential appointment time.

Cancellation of appointments must be done 24 hours in advance. Otherwise the patient will be responsible for the regular session fee.

Fee Schedule:

Initial Evaluation:	$530.00
45 minute session:	$270.00
20-25 minute session (medication visit):	$210.00
Phone Session:	$110.00 per 15 minutes
Administrative*:	$110.00 per 15 minutes

*Examples of situations in which administrative charges apply are phone calls that are more than 5-10 minutes long, writing letters, consulting with other health care providers/ family members, time spent doing prior authorizations, responding to records requests (if more than 5-10 min. required).

Payment Policy: Payment is due at the time of service. If your insurance provides out of network coverage for psychiatric services, I will provide you with a statement that you can use when filing for reimbursement. There will be a $25.00 fee per returned check.

Confidentiality: Your records and the information discussed in our meetings are confidential and will not be released unless I am authorized in writing to do so. Except as medically required and ethically permitted and with the exception of certain situations that are dictated by law (e.g. child abuse, imminent threat of danger to yourself or others, or court order), I will never communicate or release any aspect of your treatment without your consent. Information released to insurance companies for reimbursement for services must be sent by you rather than by or through my office.

Phone Call Policy: Most calls received before 2:00 pm Monday through Thursday will be returned the day you call. Calls received after my business hours will generally be returned my next business day. If you have an urgent situation after hours or over the weekend, you may contact my answering service at 770-429-2590. If you have an emergency or cannot wait for a return call, you should call 911 or go to your nearest emergency room.

Medication Refill Policy: Refills are made for patients currently in treatment and keeping regular appointments. At each visit, I will make every effort to ensure that you have prescriptions/refills for an adequate supply of medication to last until your next visit. However, **should you need a refill between visits, please call in your request at least one week prior to being completely out of your medication. Please do not wait until you are out of medication (or down to your last 1-2 doses) to call.** Leave your name, date of birth, name of medication, dosage, how often you take it, pharmacy phone number, and your phone number. Please indicate if I should not leave a message for you at this number.

Vacation Coverage: If I am going to be unavailable during a vacation, I will arrange for coverage by another psychiatrist during this time. Giving your consent for treatment with me also includes consent for treatment with the psychiatrist I have arranged to cover for me. If you do not consent to having another psychiatrist handle your care in my absence, you must note that below.

Evaluation/Referrals: Given my limited private practice office hours, and the strictly outpatient nature of my practice, my services are not appropriate for all patients requiring psychiatric care. If, after your initial evaluation (or at any point in your treatment with me), I believe that I am not able to provide the level of care or nature of services to best serve you, I will discuss this situation with you and provide you with appropriate referrals for more suitable care.

Termination of Treatment: You may elect to discontinue treatment at any time. I reserve the right to terminate treatment if I believe that I do not offer the type of care you need or if you have been noncompliant with the agreed upon treatment or the policies of my practice. Before termination of care, I hope you will discuss your decision with me, as I will with you. If I terminate the treatment, I will provide you with a referral for continued treatment. If you terminate treatment, I will also provide you with a referral for continued care at your request.

Consent for Treatment: I, the undersigned, have read and understand the agreement between me and Maurie Mintz, M.D., L.L.C and agree to be bound by its terms. I give my consent for treatment to be provided by Dr. Mintz. I further understand that I am personally responsible for any ensuing charges made for services rendered.

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Patient's Signature Date

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Patient's Printed Name