Space Coast
Psychiatry, Inc.

Private Pay Client

Patient Name: _____

By signing below, I understand that I am a Private Pay client at Space Coast Psychiatry, Inc. "Private Pay" means that I am fully responsible for all costs associated with my medical care provided at Space Coast Psychiatry, Inc.

I choose to waive using any medical or behavioral health insurance that I may or may not have. I agree to pay "usual and customary costs" associated with my care. At this time, Space Coast Psychiatry, Inc. charges: (Charges are subject to change)

$400.00 for Initial Evaluation

$200.00 per Follow-up Appointment up to 30 mins each

(additional charge may occur for appointments longer than 30 minutes)

$25.00 per letter or single page report requested outside of appointments

$50.00 per multiple page reports

**For multiple family member situations, please see Office Manager/MD for rate.

If I choose to utilize health insurance, I will contact Space Coast Psychiatry, Inc. prior to the next medical service and request to withdraw this agreement in writing, and discuss my options for continuing treatment.

_____ _____

Patient Signature (Patients 13 years or older) Date

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

(Effective 07-01-2016, Update 01/2020)

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