Terms of Treatment and Payment Policy

As a patient of Holistic Mental Health, PLLC, and as a primary, active participant in optimizing my overall health, I understand that I have certain responsibilities. These responsibilities include:

-Providing complete and accurate information regarding my history on intake.

-Regularly attending scheduled appointments on time or giving at least 24 hours of notice to cancel any scheduled appointment.

-Notifying my doctor at my next appointment of any new medications, supplements, or therapeutic interventions that I have started.

-Notifying my doctor PRIOR TO my next appointment of any inpatient hospitalizations for mental health or substance abuse reasons while receiving treatment at Holistic Mental Health, PLLC and facilitating obtaining records from these facilities by signing an appropriate release of information.

-Asking appropriate questions about my treatment both prior to starting it and any time thereafter, to participate actively and in agreement to all the details of my treatment plan.

-Consistently safeguarding my prescribed medication or supplements to ensure that it is for only my use, taking it as prescribed by my physician, and discussing any reasons I may want to stop or change the medication PRIOR TO doing so with my physician.

-Using the main office telephone number, (919) 267-9813 for all prescription refills, appointment scheduling or cancellations, and for general questions or concerns. I understand that calling the cell number is for emergencies only, but should absolutely be used if necessary. Moreover, if I am experiencing a life-threatening medical or psychiatric emergency, I will call 911 or report to my nearest emergency room and medical staff can subsequently try to reach my physician. *I understand that my inability to adhere to any of the above responsibilities may adversely impact my treatment. If consistent problems occur with my inability to adhere to these responsibilities, my treatment may be terminated and I will receive assistance in a transfer of care of to another physician.*

Moreover, I understand that payment in full is due at the time of service. Payment can be done by check or cash and returned or cancelled checks will incur a service fee of $25.00. I understand that my physician is an out-of-network provider meaning that any insurance I have will not be accepted, and though I can obtain a receipt from my physician to submit to my insurance company, the amount received from the insurance company may be less than the fee I paid at the time of service. Upon submitting my receipt to my insurance company, they should make a check out to me, the subscriber and not my physician. I understand that any pre-authorization for services as required by my insurance company is my sole responsibility to obtain. **I agree that if I give less than a 24 hour notice to cancel an appointment for any reason, I will have to pay a $25.00 service charge, and if I no show, I will pay the cost of the appointment in full. Fees for requested paperwork are $25 per 15 minutes. Additional fees for after-hours phone calls lasting longer than 15 minutes will apply.** Finally, I have read the HMH, PLLC policies either on the website www.holisticmentalhealth-nc.com or in the office manual, I have had an opportunity to ask questions about the policies, and I agree to abide by them.

I HAVE READ AND AGREE TO THE TERMS OF TREATMENT AND PAYMENT POLICY ABOVE.

Patient Name:_____ Patient Signature:_____ Date:_____

Parental Signature (if patient is a minor):_____ Date:_____

Physician Signature:_____ Date:_____