The Rajan Center for Family Wellness LLC

Shirley Rajan, MD
Child, Adolescent and Adult Psychiatrist

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Your understanding of our financial policy and participation agreement is an essential element of your care and treatment. If you have any questions, please take the opportunity to discuss them.

As our patient you are responsible for:

- Being responsible for any payments at the time of each visit.

Session fees are as follows: Initial Evaluation – 1-hour session $450
Follow-up - 30 min: $300

Any letters written to the court, lawyers, social service agencies, or schools etc. include an additional fee, as do any formal assessments if specific measures are used and scored. The extra fees associated with these services will be discussed with you in advance.

Your consistent participation in treatment is important. Treatment works best when the frequency of sessions is determined together between you and the psychiatrist. If you must cancel an appointment, a **24 hour notice** is required. **There is a Failure to Show or Missed Appointment charge of the full session fee if not canceled 24 hours prior to the scheduled time. If you call over a weekend to cancel for Monday and we are unable to fill your time with another client, you will be charged $50.00. There is also a fee of $50.00 for all returned checks.**

If you fail to give 24-hour cancellation notice on more than 2 occasions, your treatment at the Rajan Center for Family Wellness may be terminated. Also, anyone who has not been participating in treatment for the last 3 months will have their file closed, and treatment with the Rajan Family Wellness Center will be considered concluded.

All accounts past 30 days are subject to a finance charge. A late charge of 1% per month will be added to all account balances. This is an annual percentage of 12 percent. If your account becomes delinquent, you may be referred to a third party for collection.

I have read and understand the financial policy and participation agreement described above. I request that the provider named below provide professional services to me or to ___________________________ who is my ________________________.

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Signature of Patient or legal guardian Date

I, the provider, have discussed the issues above with the patient or legal guardian. I have no reason to believe that this person is not fully competent to give informed consent.

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Provider Signature Date