EMPATHIC RESONANCE, LLC

EMPATHY DRIVEN INDIVIDUALIZED & HOLISTIC CARE ©

ADULT, CHILD & ADOLESCENT PSYCHIATRIC CONSULTATIONS & SERVICES

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firas@empathic-resonance.org

OFFICE POLICIES & PROCEDURES

(Revised Jul 2018)

Name: _____ DOB: _____

Address: _____ Telephone: _____

_____

By signing this form, I hereby acknowledge that I have been informed and agree to the office policies as stated below:

1. **I hereby pledge not to use any medications prescribed to me in any form other than as it was prescribed and intended. I pledge not to overuse, misuse, resell or in any way divert to anyone else the medications prescribed to me.**
2. **I agree to submit to random urine drug tests as needed for compliance with treatment plan and progress monitoring.**
3. **To ensure safety and in keeping with standards of care and practice, I pledge to the best of my ability to continue to attend my scheduled follow up appointments regularly. I am aware that if I miss three appointments in the span of six months I will be ineligible to continue care at Empathic Resonance, LLC and will be discharged from the clinic.**
4. **I acknowledge & agree that I am ultimately responsible for all payment obligations arising out of treatment and services rendered and guarantee payment of these fees. I agree to pay all expenses including deductibles, co-payments, coinsurance amounts and any other patient responsibilities indicated by my insurance carrier as well as unpaid claims made to my insurance company and any fees not covered by my insurance. I understand that I will be charged the standard "out of network" fee of $400/hour for all services unless my insurance covers "in network" services by Empathic Resonance, LLC. I authorize Empathic Resonance, LLC to charge the credit card on file for any outstanding balance after each visit. I understand that it is ultimately my responsibility to understand my insurance policy, and I understand that failure to keep up with my financial responsibilities may result in me being discharged from the clinic.**
5. **I agree to have the credit card I have stored on file charged with any outstanding balance at the time of each service.**
6. **I have been informed that Empathic Resonance, LLC reserves the right to set its own rates for services provided, and also reserves the right to adjust these rates after giving at least one month's notice in writing.**
7. **I acknowledge that I must give at least 48 hours' notice before cancelling or rescheduling an appointment. I agree to pay $150.00 in processing and administrative fees if I do not show up to my appointment or if notice is given to reschedule or cancel an appointment less than 48 hours prior to the time of my scheduled appointment.**

Patient Signature _____ Date_____
Guardian / Financial Guarantor Signature _____