**North Texas Child Psychiatry, PLLC**

**Shauna Reid, M.D.**

**400 N. Allen Dr. Suite #103**

**Allen, TX 75013**

PH: 972-885-0715

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**Office Policies**

Please initial each paragraph below to indicate that you understand and accept the following terms:

If unable to keep your scheduled appointment, 24 hour notice is required.

\_\_\_If you do not cancel your appointment at least 24 hours in advance, you will be charged our full fee of $175 unless we are able to fill the appointment time. The same fee will be charged for no-shows.

\_\_\_There is a $50 charge on any disability/FMLA paperwork completed by your doctor. Please present your paperwork to the receptionist prior to your appointment.

\_\_\_Please note that it is the patient’s responsibility to pay any portion of bill not covered by insurance. After the insurance EOB/payment has come back, any portion not covered by insurance will be billed to your credit card on file.

\_\_\_Returned checks will be charged at $15 bank fee.

\_\_\_After 3 missed appointments; we will no longer provide services unless all missed appointments are paid in full either with cash, credit card, or check.

\_\_\_Please notify our office of any insurance changes at least 2 days prior to your appointment to avoid delays.

\_\_\_ Phone calls or email communication, completed outside of appointments, that exceed 5 minutes will be billed for.

\_\_\_There will be a $15 fee to replace lost or expired controlled substance prescriptions.

\_\_\_Records/Confidentiality: All of our communications are part of the clinical record. Records are the property of North Texas Child Psychiatry, PLLC. Most of our communication is confidential, but limitations and exceptions do exist. The following are some examples of circumstances in which information maybe be disclosed without prior consent:

1. You are a danger to yourself or someone else.
2. If there is any reason to believe that abuse or neglect of a child has occurred.
3. We are ordered by a court to disclose information or release records.
4. If records are subpoenaed, this does not indicate an automatic release of records and we may choose to seek a court order to overturn the subpoena should disclosure be deemed not in the client’s best interest.

To further protect your confidentiality, if we see you in public, we will only acknowledge you if you approach us first.

\_\_\_Court: You acknowledge that I do not agree to serve as an expert witness or to provide testimonial services for you or your family.

\_\_\_Communications: I do/do not give permission for the staff to contact me through email. I understand that it is possible for any electronic communications to be intercepted by a third party and I do not hold North Texas Child Psychiatry, PLLC or staff responsible for breach of confidentiality related to electronic transmission of information. I also understand that this form is communication is not the preferred method, email is not checked daily, and you may not get a response back via that method.

\_\_\_Emergency/Crisis: Please know that I do not provide 24 hour crisis services. Should you experience an emergency necessitating immediate mental health attention, call 911 or go to the nearest emergency room for assistance.

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Name of Patient and Parent/Guardian Date

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Signature