SHAWNA S. BRENT, MD

BOARD CERTIFIED CHILD, ADOLESCENT & ADULT PSYCHIATRIST

AGREEMENT OF UNDERSTANDING OF THE POLICIES AND FEES FOR SHAWNA S. BRENT, M.D.

Evaluation: $250

Medication Follow-Up (up to 25 minutes): $140

Extended Appointment (up to 50 minutes): $175

PAYMENT OF FEES

Payment of fee or accepted co-payment/coinsurance is expected at time of visit. Dr. Brent accepts VISA and MASTERCARD. Charges may apply for services other than direct patient care (e.g. requests for reports, telephone consults, and photocopies.) Dr. Brent may file claims for the following in-network insurance companies:

Highmark Blue Shield

Blue Cross Blue Shield (most plans)

Dr. Brent makes every effort to resolve outstanding charges mutually with patients. However, delinquent unpaid outstanding balances which are considered to be your responsibility may be referred to a Collection Agency. At that time, your outstanding balance will be charged an additional collection fee and your care will be terminated.

INSURANCE POLICY

I understand that Dr. Brent will attempt to contact my insurer to verify my mental health insurance benefits. I further understand that what is actually paid by the insurance company may be different from the information given. I agree to pay all fees to Dr. Brent that my policy specifies, once written information is received from my insurance carrier.

If I see Dr. Brent as an out-of-network provider, she will supply me with the receipt to submit to my insurance company for reimbursement. We are unable to bill out-of-network or secondary insurance plans. It is my responsibility to pay Dr. Brent directly at the time of service and submit the receipts to my insurance company for reimbursement.

LEGAL PROCEEDINGS

I agree that Dr. Brent will NOT be asked by me, or any attorney that I hire, to provide the testimony to the court, unless previously agreed upon. Such testimonies can damage the therapeutic relationship and may also expose confidential communications given to Dr. Brent.

I also understand that if I violate this agreement and legally insist on a testimony: I will be charged forensic rates ($500/hour) for ALL time involved and that these fees are not covered by my insurance.

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CAMP HILL, PA 17011
7177308555
DRB@SHAWNABRENTMD.COM

CANCELLATION POLICY

Dr. Brent requires that patients give a 24-hour advanced notice of an appointment cancellation. If no notice is given for a canceled appointment, or if Dr. Brent receives an improper cancellation, I am subject to a charge of $100. There will be NO reminder calls for appointments. It is my responsibility to remember the date and time of appointments.

MEDICATION POLICY

Requests for medication refills require 48 hours notice and can be requested through the website (www.shawnabrentmd.com). Please check directly with your pharmacy 48 hours after the request to see if the medication is available for pick up. Medication samples WILL not be available for distribution.

****If a medication requires a preauthorization from my insurance company this request may take up to one week.**

ELECTRONIC COMMUNICATION

I agree that if I choose to communicate with Dr. Brent through her website that all efforts have been made to ensure the safety and confidentiality of this communication. However, if there is a risk of failure of security as with any such transmission. This communication is intended to be used to request/confirm an appointment, request medication, or convey non-critical clinical information. Please note that there may be an additional fee for excessive email communications. **I will NOT use this for emergency services.**

OFFICE SUPPORT

An office support person will be available to do insurance billing and to answer billing concerns. This person will not be available for routine inquires. Messages left for Dr. Brent will be checked after 4 p.m. and replies will be provided in a timely manner.

CONFIDENTIALITY

Our services are confidential. Please refer to our Notice of Policies to Protect the Privacy of Your Health Information.

PARENTS ARE RESPONSIBLE FOR THE SUPERVISION OF THEIR CHILDREN AT ALL TIMES.

I have read the information above and understand all of its contents.

Patient Name (Printed)

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Signature

______________________________ Date______________________

A copy of this form is available upon request