PRIME BEHAVIORAL HEALTH, LLC
13994 Baltimore Avenue, Suite 102 Laurel, Maryland 20707
Phone: (301)-447-2128 Fax: (301)-447-1758

Policies and Procedures

PAYMENT

Coinsurance and Copays are due at the time of each visit. I hereby assume financial responsibility for and agree to make payment to Prime Behavioral Health LLC for all charges for services provided that are not authorized or paid by the insurance company. RETURNED CHECKS There is a $25.00 charge for any returned check.

CANCELLATIONS/MISSED APPOINTMENTS POLICY

(does not apply to Medicare or Medicaid clients)

If you cancel your appointment within less than 24 (twenty-four) hours notice or do not show up for a scheduled appointment, you will be charged **$50.00** for a Therapy session; **$50.00** for a Medication Management appointment; and **$50.00** for a Group session. All decisions concerning charges are made at the discretion of the providers. Any fee incurred due to a late cancellation or missed appointment is your personal responsibility, insurance companies do not reimburse for missed appointment fees. Providers have the right to cancel future visits if a client misses or cancels two consecutive appointments**.**

PRESCRIPTION REFILLS (does not apply to Medicare or Medicaid clients)

In order to maintain consistent follow-up and care, prescriptions will be provided at the time of the office visit. Pharmacy refill requests will be charged at the rate of $25.00. Please note: if prescribed any controlled substances CRISP database will be searched

CLOSED PRACTICE

Prime Behavioral Health, LLC. is a closed practice. If a patient is interested in seeing both a therapist and a psychiatrist, he/she would have to select both from this practice. This requirement promotes comprehensive and integrated care.

CONTACTS

Emergency Contact:

Last Name:_____First:_____

Cell or Home #:_____Work #:_____ Relationship to Patient_____

Please provide the name of a family member, spouse, or friend with whom you consent to allow our providers to contact to discuss treatment concerns, if necessary.

Last Name:_____First:_____

Cell or Home #:_____Work #:_____ Relationship to Patient_____

Please provide the name of your Primary Care Physician/Medical Specialist you authorize us to consult with:

Primary Care Physician's Name_____

Address:_____City:_____State:_____Zip Code:_____

Phone#:_____ Fax#:_____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION: By signing this form:

You have read and agreed to these policies and procedures.
You consent to the treatment received in this office and agree to discuss concerns with your provider.
You acknowledge receiving our Notice of Privacy Practices.
You consent to Prime Behavioral Health LLC to use and disclose protected health information for treatment, payment, and healthcare operations.
You agree to notify our office immediately of changes to your address, phone numbers, Primary Care Physician, or insurance coverage or carrier
You authorize the Psychiatrist/Therapist to consult with your Primary Care or Medical Specialist.
You permit a copy of this authorization to be used in place of the original which may be revoked in writing.

RESPONSIBLE PARTY SIGNATURE: _____

DATE: _____