Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

OFFICE APPOINTMENTS, FEES, AND CANCELLATION POLICY

Our office tries to meet the needs of all of our patients but in particular our patients in crises that need our urgent attention. To open up appointment slots for patients in crises, the following scheduling policies are implemented:

1. To schedule an appointment, please call our office at 317-978-0257 or schedule online at indybehavioralhealth.com _____ **(initial)**

2. One day prior to the appointment, the office will try to reach you directly to confirm the appointment. If we are unable to reach you, we will try your alternate contact information. Please be aware, though, that this reminder service is a **courtesy** to our patients and that they are ultimately responsible for charges incurred due to a missed appointment. _____ **(initial)**

3. We understand that there may be circumstances that are beyond your control and we will try to accommodate them as best we can. However, there is a **24 hour cancellation** policy. You can cancel or re-schedule your appointment anytime 24 hours **before** your appointment. If the appointment is cancelled less than the 24 hour period or missed completely without notification the following consequences apply:

Cancellations: We ask that you provide 24 hour notice for appointments that must be cancelled and or rescheduled. Less than 24 hour notice and or not showing for appointment will result in a missed appointment fee of $150.00. Appointments must be cancelled by calling the front office at 317-978-0257

CREDIT CARD POLICY

1. The patients' credit card information will be provided to the office and charged the next business day for the missed appointments and other fees incurred during treatment. _____ **(initial)**
2. Your credit card is used exclusively for charges incurred in the office.
3. Unfortunately, services cannot be rendered unless valid credit card information is provided. _____ **(initial)**

I have read the above and agree to its terms and conditions.

_____

Signature of Patient or Guardian if patient is under 18. Date

_____

Printed Name

Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

PAYMENT POLICY

Payment is to be paid in full at the time of appointment. Accepted forms of payment include credit or debit cards. I do not participate with any commercial or private insurance companies including Medicare or Medicaid. Please contact your health insurance carrier about your out-of-network mental health benefits. Upon request, you may be provided a super-bill. This provides the necessary information to submit to your insurance carrier for possible out-of-network reimbursement. _____ **(initial)**

WRITTEN REPORTS

Occasionally, requests are received for reports, treatment reports for insurance companies, and written evaluations to be sent to individuals or agencies. You will be billed for the time required to complete such reports, as well as clerical costs. _____ **(initial)**

I have read the above and agree to its terms and conditions.

_____

Signature of Patient or Guardian if patient is under 18. Date

_____

Printed Name

Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

COMMUNICATIONS

Email

Email is not a secure form of communication.

Email messages may be read by staff when handling routine, non-clinical matters.

Email may be printed and placed in your medical record. Employers may choose to read email sent from work and have the legal right to do so.

Email may be forwarded to staff for handling, if appropriate.

If you have a question about changing your medication, you will need to schedule an appointment.

Email can not adequately inform you of the risks and benefits of changes in treatment.

Email is NEVER appropriate for urgent or emergency problems! In an emergency, call 9-1-1 or go to the nearest emergency room.

Text Messaging is also to be limited due to lack of security and confidentiality. Text messaging may be used to inform of appointment date/time or other non-clinical, routine information. It should not be used to discuss lengthy concerns including side effects, medication changes, treatment planning, etc. Questions/concerns related to medication or treatment planning deserve a greater level of attention and care. These issues should be addressed by scheduling an appointment.

After-Hours Emergencies

This clinic does not have an after hours service. If you think you may be in an emergency situation (thinking or planning to harm yourself or someone else, medication side effects or withdrawals, ect), then this is an Emergency and you should call 9-1-1 or go to the closest Emergency Department.

Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

COMMUNICATIONS

I do want to communicate with Sonya Ruedlinger, NP electronically. I have read the above information and understand the limitations of security of information transmitted.

Email Address _____

I do NOT want to communicate with my physician electronically. However, if I do email Sonya Ruedlinger, NP I am automatically authorizing Sonya Ruedlinger, NP to email me in return.

Patient Signature _____

Date _____

Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

Credit Card Authorization Form

The information on this form will remain strictly confidential.

If the name on the credit card is different from my own, I do hereby grant permission to Sonya Ruedlinger to discuss appointments dates kept and missed to the credit card holder as necessary in order to collect payment.

Patient Signature _____

CREDIT CARD INFORMATION

Type of Credit Card VISA American Express Master Card Other _____

Credit Card Number _____

Expiration Date _____

CCV Code _____

Credit Card Billing Address

Street Address _____

_____

City State Zip Code

As the credit card holder, I authorize Sonya Ruedlinger charge my credit card for future services, communications, and late cancellations or no show fees.

Disputes that I have regarding charges will be addressed directly with Sonya Ruedlinger and staff. I will not dispute charges with the credit card company.

Signature and Date _____

Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

STANDARD FEE SCHEDULE

Thank you for choosing our office for your psychiatric needs. We strive to provide a warm and compassionate environment while addressing the presenting psychiatric issues with the utmost level of professionalism and sensitivity.

1.	**INITIAL EVALUATION**:	**$250** (60 minutes)
2.	**EXTENDED MEDICATION MANAGEMENT**	**$200** (40 minutes)
3.	**MEDICATION MANAGEMENT** (uncomplicated)	**$150** (30 minutes)
4.	**LETTER REQUESTS** (brief)	**$30**
5.	**LETTER OR WRITTEN REPORT REQUESTS** (detailed)	**$ 50 and up** (depending on time)
6.	**BILLING SUMMARIES** (extra copies)	**$ 30**
7.	**MEDICATION PRIOR AUTHORIZATIONS**	**$25**

*** PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT. _____ (INITIAL)**

I have read the above and agree to its terms and conditions.

_____

Patient Signature or Parent/Guardian Date

_____

Printed Name