The Center *for* Healthy Minds

Office Policies and Procedures:

		Dr. Rothbort	Dr. Sullivan
Initial Evaluation	(>one person present)	$1300.00	$995.00
Initial Evaluation	(one person present)	$800.00	$675.00
Follow up Session	(20-30 minutes)	$375.00	$300.00
Follow up Session	(45 minutes)	$500.00	$400.00
Emergency Phone Consultation		$12.00 per minute	

		Avigail Rotberg, PA
Initial Evaluation	(>one person present)	$700.00
Initial Evaluation	(one person present)	$500.00
Follow up Session	(20-30 minutes)	$250.00
Follow up Session	(45 minutes)	$325.00

- Missed appointments will be billed according to the regular fee schedule unless cancelled at least 48 business hours in advance**.** This gives us adequate time to schedule another patient in that time slot. More than two missed appointments or late cancellations may be grounds for termination of treatment.

- Late arrivals will be billed according to the regular fee schedule**.** If you arrive late to a scheduled appointment, we will see you for the remainder of the session. If you arrive after the appointment time has ended, the appointment must be rescheduled. In either case, full payment is expected. We are aware that often there is a high volume of traffic en route to this office. Please leave ample time to arrive on time for your appointment.

- Unused session time will be billed according to the regular fee. If you complete your appointment in less than the scheduled time, you will still be charged the regular fee as written above.

- We are an out-of-network provider and do not accept insurance. We do not participate with insurance plans because they often dictate the type, frequency, and amount of care they will allow, which impairs my ability to provide optimal treatment. We are not Medicaid providers and do not bill Medicaid. Therefore, full fees are to be paid directly at the time of service. Insurance claim forms must be filled out by the patient/family with reimbursement sent directly to the patient/family.

- In order for a patient to receive a medication refill, speak to the doctor, or have forms completed, he/she must be a current patient. That entails having been seen within the last 4 months and having a follow up appointment scheduled within three months.

- Outstanding balances are not permitted. Full payment must be made before new appointments can be scheduled. Non-payment will be grounds for termination of treatment.

- There may be an additional charge for emergency appointments.

- If the patient requires treatment while out of New York or New Jersey, please discuss your options with us.

- In families where the parents are separated or divorced, the parent who initiates treatment is responsible for payments.

- Patients must be seen at least once every three months**.**

- The doctor will speak on the telephone for emergencies only**.** If you have a question or concern between appointments, please explain your question to the office staff, who will speak to the doctor and call you back with a reply. In certain situations, if you feel you must speak to the doctor directly, phone consultations are charged at the rate of $12.00 per minute. This does not replace regular appointments.

- Medication changes are not made over the phone.

- Case Management Fees**:** Clinical work with children and adolescents often involves collateral contact with teachers, other physicians, and other professionals. In order for me to speak with these professionals, a release must be signed to give me permission. I understand that phone contacts will be billed at a prorated fee of $12.00 a minute. Phone contact includes communication with the patient, family members, school, other providers, etc.

- Reports: Formal reports are not included in the initial evaluation fee. If you require a formal written report, please allow 2-3 weeks from the time of request until receipt. Reports are extremely time-consuming and take many hours to complete. The cost for an additional report will be determined based on the time involved in its preparation.

These policies will enable us to provide the best possible care to you and your family. Thank you for your cooperation.

Signing below indicates you have had the opportunity to read this document and ask any questions, understand the terms of this document, and agree to follow them.

_____ _____

Patient/Parent Signature Date