AGREEMENT OF UNDERSTANDING
OF THE POLICIES AND FEES FOR
SHAWNA SMITH BRENT, MD

Service	Fee
Evaluation	$200
Psychotherapy (50 min.)	$165
Medication Visit (25 min.)	$110

PAYMENT OF FEES
Payment of fee or accepted co-payment/co-insurance 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 insurance companies:

Highmark Blue Shield

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.

INSURANCE POLICY
I understand that Dr. Brent will 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. It is my responsibility to pay Dr. Brent directly and submit the forms 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 ($250/hour) for ALL time involved and that these fees are not covered by my insurance.

CANCELLATION POLICY
Dr. Brent requires the patient 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 $50. There will be NO reminder calls for appointments. It is my responsibility to remember the date and time.

MEDICATION POLICY

Requests for medication refills require 48 hour notice and can be requested through the website (www.shawnabrentmd.com) or by leaving a message. Medications which are permitted to be called to a pharmacy will be done so by 7 PM. Please check directly with your pharmacy after that time to see if the medication is available for pick up. There will be no notification from Dr. Brent that this occurred. Medication samples will NOT be available for distribution.

Stimulant medications will need to be mailed to the home. I will provide self- addressed stamped envelopes to Dr. Brent. Failure to do so may prevent me from receiving the medication.

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

ELECTRONIC COMMUNICATION

I agree that if I chose to communicate with Dr. Brent through her website that all efforts have been made to ensure the safety and confidentiality of this communication. However 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. 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 inquiries. Messages left for Dr. Brent will be checked at 4 PM and replies will be provided in a timely manner. Email communication will be checked throughout each day at times around 8 AM and 2:15PM.

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__________________

I was offered a copy of this form