Practice Information, Office Policies, and Consent to Treat JAN, 2018

Dr. Mitchell provides thorough psychiatric evaluation(s), diagnostic tests, psychotropic medications, if indicated, as well as psychotherapy in treating mental health problems. Dr. Mitchell's practice is exclusively an office-based consulting practice. Her practice is fully independent and is not affiliated with other agencies or persons who share office space at 910 Gruene Road, Bldg 1. Dr. Mitchell does not do hospital work, perform emergency medical services, or provide after office hour care. Consequently, Dr. Mitchell strongly recommends that in addition to her care, that you maintain a relationship with your primary care doctor and any required medical specialists. **If the occasion arises when urgent care or emergency services are needed, contact your nearest urgent care or emergency room, call 911, or contact the Crisis Center of Comal County at (800) 434-8013, where you can receive care from specialty trained professionals.**

OFFICE HOURS | CONTACT INFORMATION Dr. Mitchell is available for scheduled appointments Monday through Thursday 9p-2a. Office staff is available to answer your calls Monday through Thursday 9-4, excluding holidays. Non-urgent calls will be returned during Dr. Mitchell's office hours. Please notify office staff if your call is urgent and Dr. Mitchell will be contacted sooner. After hours Dr. Mitchell can be reached (for urgent matters only, please) on her cell phone at (830) 837-2572. If Dr. Mitchell is away or on vacation, she will have a psychiatrist covering for emergencies. Please leave a message with your name, telephone number, and concern. If your call is not returned within an hour, please call back. Please do not use text messaging; Dr. Mitchell's voicemail will provide you with additional contact information should she be away or on vacation.

NON-PARTICIPATING or OUT-OF-NETWORK Provider or NON-COVERED Benefits As Dr. Mitchell does not participate with any health insurance carriers, you are responsible for paying for all services at the time of service. If insurance coverage is available for the services rendered, a receipt with the required information is provided, which you can attach to an insurance claim form and mail into your insurance company. **Dr. Mitchell has opted out of Medicare, Medicaid, and Workman's Comp, therefore claims cannot be submitted to these agencies for reimbursement by patients.**

PRESCRIPTIONS | REFILLS If you are on medication(s) prescribed by Dr. Mitchell and you need renewals prior to your next follow-up visit, **please have your pharmacy contact the office.** Dr. Mitchell will eprescribe medications during her office hours. Please allow at least 48 hours for this process. **There is a $15 charge for refills between appointments.**

PAYMENT| DISHONORED CHECKS You are responsible for payment of charges at the time of service. Our office accepts cash, personal checks, Master Card, or Visa. There is a $25 fee for returned checks.

MISSED APPOINTMENTS OR ARRIVING LATE It is important that you appear for all scheduled appointments and that you arrive on time. Dr. Mitchell respects that you have a busy schedule too and does not over book. You will be responsible for paying a **missed appointment fee of ½ your missed appointment fee** if you fail to appear (or appear more than 15 minutes late) for a scheduled visit and have not provided at least **24 hours advanced notice of cancellation**.

FEES* * Fees are subject to change

Initial evaluation	$400			Prescription refills btwn appts	$15
Medication follow up/ therapy:		Phone calls	$55-165	ADHD medication refills	$15
20 min follow up	$150-165	Letters, Medical Forms,		Photocopies of records	
50 min follow up	$195-260	or Reports	$75/ 15 min	1st 20pages	$25
Consultations	$275/hr	Return check fee	$35	Each page after	$0.50/page

RELEASE OF MEDICAL INFORMATION Any services or communications with Dr. Mitchell is considered confidential; any disclosure of information and/or records related to your care will only be done by your authorization or court subpoena.

I have executed this consent freely and willingly, and understand its provisions. I have read, understand and agree to the above. I recognize that Whitney H. Mitchell, MD will rely upon my execution of this document as my consent for treatment. I understand that achieving my treatment goals is a partnership and that Dr. Mitchell does not guarantee treatment results.

Signature: _____ Date: _____