Lilyfield Psychiatry of Atlanta, P.C.
Child, Adolescent and Adult **Psychiatry**
and **Psychotherapy**

800 Old Roswell Lakes Pkwy, Suite 260
Roswell, GA 30076
P(770)545-8799/ F(770)545-8797

CREDIT CARD POLICY AND CONSENT FORM

I, the undersigned, understand that a credit card on file is required to be an active patient. I, the undersigned, authorize Lilyfield Psychiatry of Atlanta P.C. to charge the credit card that I place on file for the following services or conditions:

1. Missed appointments or cancellations made less than 48 business hours from the time of scheduled appointment. These missed appointment fees are listed below:
   i. $400.00 for an initial intake with a psychiatrist (MD)
   ii. $175.00 for a follow-up appointment with a psychiatrist (MD)
   iii. $175.00 for an initial intake with a therapist
   iv. $125.00 for a follow up appt with a therapist

2. Medication Refill Fee: $25 for any medication prescribed in between appointment times.

3. Co-Payments (unless otherwise specified or requested at the time of the appointment.) Please note that any patient who has an appointment scheduled after 4pm or on a Friday may have their copay charged on the following business day.

3. Any claim that is denied secondary to insurance being inactive at the time of service, or due to failure on the part of the patient or responsible party to obtain prior authorization or referral and/or complete forms required by the insurance company to process the claim. Any insurance claim that becomes more than 90 days past due after proper filing and at least 1 re-filing by our billing company

5. Prior Authorization Fee: $25 to complete any medication prior authorization that may be required by your insurance company.

6. Medical Records Fee: $25 plus $0.25 per page for a copy of your medical records.

7. Brief Forms/ Letters for your clinician to complete outside of session times: $25

8. Any outstanding patient balance that becomes more than 30 days past due

9. Any bounced check amount plus a $50 bounced check fee

***I, the undersigned, understand that this form will be valid for the duration of my treatment with this office UNLESS I cancel through written notice to Lilyfield Psychiatry of Atlanta P.C.

Patient Name:___________________________________ Patient DOB:_______________________

Card Holder Name: ___________________________________

Card Holder Signature: __________________________________ Date: ______________________________