HORIZON PSYCHIATRY

TREATMENT AGREEMENT

I understand Horizon Psychiatry, LLC is providing psychiatric treatment for Mental Health conditions which may include the initiation or continuation of psychotropic medications. This treatment agreement will give us the opportunity to work together and establish a treatment plan to help improve overall quality of life.

1. I am consenting to treatment services and will work with my provider to establish a treatment plan that may include psychotropic medication management and referrals to therapeutic services.

2. Claims will be submitted to all insurances, disclosed by patient prior to time of service, for payment. Any remaining balances after claims have been processed by insurance companies will become patient responsibility, if applicable.

3. Additional charges may include brief psychotherapy and interactive complexity along with medication management codes dependent on provider's discretion based on acuity of visit. Itemized charges will appear on your billing statement.

4. Laboratory testing may be requested by your provider before initiating treatment and throughout the course of treatment. Horizon Psychiatry, LLC does not offer laboratory services. Orders will be given and it is the patients responsibility to bring orders to their laboratory of choice to be completed. Laboratory testing fees are patient's responsibility.

5. Refill requests for medication may take up to 5 business days. Controlled substances will not be filled earlier than 3 days before they are due. Please make refill request 5 business days prior to ensure a timely refill.

6. Horizon Psychiatry will return messages within one business day.

7. I agree to attend regularly scheduled appointments for ongoing assessment necessary for continuation of medication, as well as all other services provided by Horizon Psychiatry, LLC.

8. Horizon Psychiatry, LLC requires a 24-hour cancellation notice for all scheduled appointment. Appointments cancelled without a 24-hour notice, missed appointments, or showing up late (will result in late cancellation) will be assessed a $120.00 fee. This fee will be the responsibility of the patient and will not be submitted to insurance for payment.

9. I understand that if I arrive late for my scheduled appointment this appointment will be cancelled. A new appointment may be scheduled not earlier than the following business day.

10. I understand if I cancel (without 24-hour notice) or miss scheduled appointment 3 times in a 12 month period my care will be terminated at Horizon Psychiatry, LLC.

11. Horizon Psychiatry, LLC does not offer after hours' service. Hours of clinic operation are Monday through Thursday from 7am to 5pm. If immediate assistance is needed, please call 911 or report to the nearest emergency services facility.

12. Dishonest or disrespectful behavior will not be tolerated at Horizon Psychiatry, LLC and will result in immediate termination. (i.e. disrespectful, profane, or aggressive language, aggressive behavior or threats).

By signing below, I agree that I have read and understand all information provided on this form.

Patient signature (or legal guardian) _____Date _____

Provider signature _____Date _____