Mindful Medicine
Initial Psychiatric Evaluation

Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Email: _____

Date of Birth: _____ **Age:** _____

Primary care Physician: _____

Primary Care Physicians Name and phone number: _____

_____

Preferred Pharmacy Name and Address: _____

_____

Please indicate name address, phone number and relation to patient if a third party is responsible for payment:

_____

_____

_____

Please initial each line in agreement prior to evaluation

_____[initial] I understand that information provided is confidential. It will be documented in a chart. I also understand that certain information is neither privileged nor confidential, including but not limited to, threats of harm to self, threats of harm to others, suspicion of child or elder abuse, failure to pay bills to my provider etc.

_____ [initial] I understand I am responsible for payment in full for all charges at the time of service and that failure of payment will be sent to collections if not received in a timely manner.

_____ [initial] I understand that any appointment must be cancelled at least 48 hours in advance or a full charge will apply.

_____[initial] I understand that if I miss more than 2 consecutive appointments or more than 4 appointments total in 6 months that your chart will be closed, and due notice will be considered automatically given.

_____ [initial] I understand that no medication refill request will be honored with less than 3 working days' notice, and that no medication refill request will be honored unless there has been an office visit within the past 60 days.

_____ [initial] I understand that there is no supervisory or liability inducing relationship between any providers care in this office or office complex; any form sharing and/or office sharing does not constitute a partnership or any form of hierarchical structure. All providers are entirely independent providers. None of them hold any liability for actions of the other in any manner.

I consent, assent and request evaluation and or treatment by Dr. Barness or a member of his team. I understand that treatment does not guarantee symptom resolution and that some individuals may show no improvement or even worsen.

Signature: Date:

Dr. Barness or his practice do not accept any form of insurance, including Medicare and Medicaid. Payment must be in the form of cash, check, or credit card. A $50 fee will be charged for any check with insufficient funds. I understand this billing policy and I choose to waive all insurance benefits regarding payment for services.

Signature: Date:

If I have Medicare or Medicaid, I choose to waive my benefits for serviced with this provider.

Signature: Date:

Fee Schedule for Mindful Medicine LLC

Initial 60-minute Psychiatric Evaluation - **$500**

50-minute Medication Management + Psychotherapy follow up - **$500**

30-minute Medication Management follow up – **$250**

I understand and agree to pay the above described fees for services for Mindful Medicine LLC.

Signature: **Date:**

How did you hear about us?