David J Posey, MD, LLC
9106 North Meridian Street
Suite 210
Indianapolis, IN 46260
Tel No: (317) 341-4575
Fax No: (317) 706-0249
Email: dave@drposey.com

Patient Information and Office Policies

Patient Information

Last Name	First Name	Middle Name
Birthdate	Gender	
Home Address		
City	State	Zip Code
Home Phone ( )	Mobile ( )	
Primary Care MD (First and Last Name)		Office Phone
Primary Care MD Address		
City	State	Zip Code

Person Responsible for Payment (if different from patient)

Last Name	First Name	
Relation to Patient	Birthdate	
Home Address		
City	State	Zip Code
Home Phone ( )	Mobile ( )	

Alternate Contact Information (e.g., parent of minor or guardian if not listed above)

Last Name	First Name	
Relation to Patient	Home Phone ( )	Mobile ( )

Thank you for providing the above information. I also request that you read the following policies and sign this document prior to the first visit. Please call me at (317) 341-4575 if you have any questions before your appointment. A copy of the below information will also be provided to you.

Exchange of Mental Health Information: If you want me to send a report and/or periodic updates to your primary care physician or therapist, please complete an **Authorization for Exchange of Mental Health Information** Form for each provider (attached). Primary care physicians often appreciate this especially if medications are being used. Additional forms are available if needed. These forms can also be used to authorize communication between providers or other important people in your care.

Payment Information: I am not contracted with any insurance companies. Payment by cash or check is due at the time of the visit. You will receive a receipt listing all of the information necessary to access your out-of-network benefits or health savings accounts. My current fee schedule is as follows:

Initial Evaluation (60-90 minutes)	$400
20-30 minute Follow-up Visit	$190
45-60 minute Follow-up Visit	$290

There is a $30 fee for returned checks in addition to any bank fees.

Medicare/Medicaid/Tricare: I am not a Medicare, Medicaid, or Tricare provider. You must inform me if you have either Medicare, Medicaid, or Tricare. Medicare, Medicaid, and Tricare will not reimburse you for any of your costs.

Phone Calls: When leaving a message, please leave your name and telephone number. I attempt to return patient calls within a day of receiving them. If you have not heard back from me soon enough, please call and leave me another message. If you have a psychiatric or medical emergency that cannot wait for my call, please call 911 or go to the nearest emergency room. **If you are requesting a refill**, please leave the patient's name, date of birth, medication name, strength, and dosing (e.g., fluoxetine, 20 mg, take one daily) as well as your pharmacy's telephone number. Stimulants refills cannot be called in to the pharmacy. If you need a stimulant prescription, leave your address to which I should mail the prescription.

Missed Appointments/Cancellations: Please notify me at least 24 hours in advance if you need to cancel your appointment. If you miss your scheduled appointment, you may be charged for the missed visit.

Treatment of Minors: The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service.

Agreement to Financial and Office Policies: I have read and completely understand the policies stated above and I agree to accept full responsibility as described. If I am agreeing on behalf of a minor, I affirm that I have the legal right to consent and agree on behalf of that minor.

_____ _____

Name Date