Andrew E. Leifer, M.D., P.C.
1202 Bergen Parkway, Suite 211
Evergreen, Colorado 80439
Phone: 303-674-6074

OFFICE POLICIES

Thank you for choosing me as your health care provider. The following are policies of this office. If your concerns are not addressed, please raise any questions during your appointment.

Appointments: Initial evaluations are usually scheduled for 1 hour and 30 minutes. Psychotherapy sessions are 45 minutes.

Cancellation Policy: Please give **72 hours** (business days) notice to avoid being billed for a prearranged appointment. If shorter notice is given, but the time can be filled, there will be no charge.

Prescriptions: Prescriptions are written to last until your next appointment. Please schedule your next appointment so that your prescription will not lapse in the interim.

Vacations: I will give you notice for my planned vacations when they conflict with a scheduled appointment. Coverage will be provided by another psychiatrist who may be reached by calling my office.

Payment: Full payment is due at the time of service. I accept cash, checks or major credit cards. I am not a participating provider for insurance companies, however I can provide a HICFA form (standard insurance company billing form) on a monthly basis for paid services that you to submit to your insurance company for direct reimbursement. The full fee for your appointment is due at the time of your appointment. Since there is great variability in insurance coverage for psychiatric services, please address specific questions concerning your policy with your individual insurer. You are responsible for obtaining a referral for psychiatric care if your policy requires this. In the event of unpaid or overdue balances you will be responsible for repayment of the debt including but not limited to the principle balance due, reasonable attorney fees, court costs, and costs of collections. My office charges 18% per annum interest on the unpaid debt and $15.00 per month rebilling fees on any overdue balances not paid promptly. A fee of $30.00 will be charged on returned checks plus any bank charges I am billed for regarding your returned check. **We do not accept MEDICAID recipients. Please inform Dr. Leifer or APEX Treatment Services if you are a Medicaid recipient or become a Medicaid patient during the course of treatment.**

Confidentiality: No information will be released to anyone about you without your signed consent except in life-threatening emergencies and as required by law. I do not release copies of your chart to other parties, even with a release of information signed by you, but instead will provide a written treatment summary after discussion with you.

Substance Abuse: In the event substance abuse is an issue in your treatment, I reserve the right to order laboratory studies, including toxicology screens, to further evaluate this.

Telephone Messages: I check with my office and my voice mail daily on weekdays. I return phone calls during working hours. Phone calls left after working hours and on weekends may not be answered until the next working day. If your call is an emergency, first leave me a voice mail message, then page me. (Instructions are available on my voice mail.) I try to return pages within two hours. I have a call group of psychiatrists which may cover for me on weekends and vacations. Phone calls exceeding 5-10 minutes in duration or requiring decision-making may be billed at my standard rates.

Office Hours: I am generally in the Bergen Park office on Tuesday thru Friday. I do check messages on the weekdays I am not in the office.

Report Writing and Billing: I charge for report writing and treatment summaries that you request at my standard hourly rates. Any reports for the legal system, or that may involve legal testimony, are billed at my forensic rates. Please request additional details should this be relevant to your situation. I bill for my time spent in your care and treatment. Generally I do not bill for contact with other health care providers for continuity of your care. Exceptions may apply in emergency situations or when extended contacts are required for complex problems. Administrative/clerical time dealing with your insurance company, obtaining prior authorizations for medications and other billing matters will be billed at my discretion.

Your signature below indicates that you understand and agree to these policies. I require that all my patients sign this form prior to the first session.

Printed Name:____ **Date:** __________________

Signature:____

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