

## Meadows Psychiatry LLC Patient Financial Policy

1) I agree to pay for the fees listed below for professional psychiatric services rendered to me by Dr. Richard Wu, D.O. of Meadows Psychiatry LLC:

Initial Psychiatric Evaluation: \$200

Medication Management: \$100

No Show Fee/ Cancellation or Rescheduling my appointment with less than 48 business hours' notice: \$100

Telephone call requested by the patient, 1-10 minutes: \$25

Telephone call requested by the patient, 11-20 minutes: \$50

Telephone call requested by the patient, >20 minutes: \$75

2) I agree to pay for any time spent on my patient care outside of my scheduled appointment time on a prorated basis. Some examples include, but are not limited to:

a) No shows/rescheduling with less than **48** business hours' notice: \$100

For example, if my appointment is on Monday at 4pm, I will communicate my cancellation no later than the previous **48 business hours** at 4pm; if an appointment is on Tuesday at 10am, I will communicate no later than **48 business hours** at 10am.

b) Phone calls, messages in my patient portal, voicemails, letters, and telemedicine appointments between me and Dr. Wu, my other physicians, therapists, teachers, family members, insurance companies, etc.

c) Non-controlled prescription medication refills outside of my scheduled follow-up appointment time. Refills for controlled prescription medication can only occur during my scheduled follow-up appointment (if deemed medically appropriate by Dr. Wu), due to strict DEA and Maryland prescribing laws.

d) Time spent obtaining prior authorizations

e) Coordination of care for emergencies, hospitalization, intensive outpatient, residential treatment, rehabilitation, etc.

f) Filling out forms (doctor's notes, letters, or reports) and reviewing charts/prior medical records. There is a **\$50** fee for filling out forms and reviewing charts/prior medical records, if Dr. Wu spends less than 30 minutes performing these tasks. There is a **\$75** fee for filling out forms and reviewing charts/prior medical records, if Dr. Wu spends greater than 30 minutes performing these tasks

g) There is a **30%** finance charge each month and a **\$50** late fee for balances more than 30 days past due, and they may be submitted to collections after 30 days, along with any associated collections fees

h) There is a **\$36** fee for returned checks (which will also result in my credit card automatically being run for the balance due)

i) There is a **\$15** fee for credit card chargebacks that are unsubstantiated

3) I am financially responsible for all charges, whether or not:

a) Insurance pays for any services

b) Dr. Wu and I decide to proceed with treatment

c) Treatment is successful, for which there cannot be any guarantee

I affirm that I am an authorized user of the credit card and/or debit card whose number and expiration date I have supplied and I do authorize its use for all fees incurred.

By signing this form below, I confirm that I have read the above and agree to these terms and conditions as described above.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature