HAUSER CLINIC & ASSOCIATES

PSYCHIATRY
Donald E. Hauser, M.D.
Bernard M. Gerber, M.D.
Arturo F. Rios, M.D.
Hayley E. Maislos, M.D.
Lindsay M. Raymer, M.D.

5959 West Loop South, Suite 600
Bellaire, TX 77401
713-669-0303
FAX: 713-669-07074
www.hauserclinic.com

CHILD & ADOLESCENT PSYCHIATRY
Karen D. Snyder, M.D.

PSYCHOTHERAPY
Cheryl A. Verlander, LCSW

HAUSER CLINIC & ASSOCIATES Professional Services Agreement

This document contains important information about professional services and business policies. Please read it carefully and note any questions you have so that you can discuss them with your physician or staff. Once signed, this document will represent an agreement between you, the patient, and Hauser Clinic.

- Office Hours are Monday through Thursday 8:30 -5:30, and Friday, 8 a.m. to 5 p.m. (Physician schedules vary)
- Patients are seen by appointment only.
- The frequency and length of follow up visits is determined through mutual discussion between the physician and the patient.
- Phones are answered Monday through Friday, 8:30 am -5:00 pm and our office is closed for lunch from 12 pm – 1pm. (Please feel free to leave a voice mail during this time if you would like a return call).
- For emergency/after-hours calls during the week, follow the prompts on our main phone number to reach your physician. For weekend emergencies/after-hours calls, call our main line and follow the prompts for the physician on call. *****Please note Emergencies/After Hours calls are NOT for refill requests – those need to be handled during normal business hours.***

Fees

- Initial Assessment/Consultation: $375 (Requires $50 deposit to book appointment)
- Medication Maintenance (15 minutes): $110
- Medication Management and Psychotherapy (30 minutes): $180
- Medication Management and Psychotherapy (45 minutes): $250
- Medication Management and Psychotherapy (60 minutes): $325
- Family Therapy with/without Patient: $325 **fee can vary due length of visit
- Letters and/or Forms: $15 - $100 depending on length of form and physician prep time
- Coordination of Care (with other health care professional, facility, or family member): $15 - $325
- Medical Records: $25
- Controlled prescription refill (ex: Adderall, Vyvanse, etc.) written outside a scheduled appointment: $15 per script. **We charge for replacement scripts if patient lets script expire and/or losses script.**

Payment Policy

- Payment is due at the time of service by cash, personal check or credit card. If a check is returned due to insufficient funds, you will be charged for the bank fees incurred.
- If you would like to submit a health insurance claim, a statement with billing codes will be provided so that you may submit your own claim. HCA Physicians, (excluding Dr Rios patients), are considered out of network providers as they do not accept any forms of insurance, except for some Medicare patients.

****All patients are required to have a Current Credit Card on file during your treatment with Hauser Clinic****

Appointment Cancellations

- Patients unable to keep their appointments must notify our office 24 hours in advance to avoid a cancellation fee.
- Patients who no show or fail to cancel an appointment 24 hours in advance will be charged the full fee of their appointment. Your credit card on file will be charged the cancellation/missed appointment fee the day and time of your missed appointment.
- Patients who miss 4 appointments without notifying our office may lose eligibility for services.
- Patients who arrive past their scheduled appointment time may be asked to reschedule and your credit card on file will be charges your appointment fee.

Medication Policy

- Abruptly discontinuing or skipping doses of your medication is not advised and may cause unpleasant or dangerous symptoms.
- It is the patient's responsibility to monitor the amount of medication and the number of refills you have remaining.
- Lost or stolen medications will be replaced at the discretion of your physician. If replaced, a replacement fee of $15 will be charged to your credit card on file.
- If you take more medication than prescribed, you may not be able to receive early refills.
- From the time of your refill request, please allow one week to obtain refills at your local pharmacy and two weeks to obtain refills via mail-order pharmacies.
- Controlled prescriptions require 24 hours request prior to obtaining a script.
- If Provider allows for controlled prescription to be mailed - patient is to provide self-addressed/ stamped envelopes.

    - I understand if I am unable to keep an appointment, I will call at least 24 hours in advance in order to avoid cancellation fees. The cancellation fee is the same cost of the missed appointment.
    - I understand my card will be charged $15 for each replacement for any lost, stolen, misplaced, destroyed or expired prescription. I understand that I am required to file a police report for any lost, stolen or misplaced controlled substance prescription before I can receive a replacement prescription.
    - I understand there is a fee for completion of paperwork, including, but not limited to, disability, letters to employers and/or educational institutions, etc.
    - I understand that as the patient, or guardian of the patient, I am financially responsible for payment of services, fees, and any unpaid balances. I understand I am financially obligated for treatment received from Hauser Clinic & Associates, as stated above, and agree to pay for any and all services received. I understand that my debit/credit card will be charged at the time of service, including fees for missed appointments and/or late cancelled appointments.

I have reviewed HAUSER CLINIC & ASSOCIATES Professional Services Agreement and acknowledge and understand it.

Patient/Parent/Legal Guardian Signature_____Date_____

Witness Signature_____ Date_____

HAUSER CLINIC & ASSOCIATES

Permission to Bill Credit Card on File **Patient Name: _____**

DOB: _____

I, _____, give Hauser Clinic & Associates permission to bill my Credit

Card #_____

CSC (_____)

VISA/MC/DISC/AMEX

expiration date_____ for a payment for session/ fees.

Please provide the following information in order to process your payment: **This information should reflect the information provided to the credit card company.*

Billing Address:_____

Phone Number:_____

City:_____ State:_____ Zip Code:_____

I understand that if I do not give 24 hours' notice to cancel an appointment, I will be responsible for the full cost of the missed appointment and it will be charged to my credit card on file.

I understand Hauser Clinic & Associates will keep this information on file for billing, unless otherwise directed by me.

Patient/Parent/Legal Guardian Signature_____ Date_____

Witness Signature_____ Date_____