ABDUL KHALID, MD, P.A.
312 W Millbrook Road, Suite 121, Raleigh NC 27609-4398
Phone: (919) 648-0281 | Fax: (919) 400-4505

OUTPATIENT SERVICE CONTRACT

PATIENT NAME: _____

Thank you for choosing Abdul Khalid, MD, P.A., for your mental health care. Please take a moment to review our policies and procedures, and feel free to contact us with any questions.

PAYMENT POLICY

Payment is required at the time of service. If you have insurance, we are obligated to collect co-pays and deductible payments at each visit.

INSURANCE COVERAGE

If we have a contract with your insurance company, we will file claims on your behalf. However, it is your responsibility to understand your benefits before receiving services. If your insurance requires a referral or preauthorization, you must obtain it. You are responsible for any services not covered by your insurance.

SELF-PAY FEES

- Initial Evaluation/Single Consultation (New Patient): $325 (cash)
- Individual Session (45 minutes): $150 (cash)
- Family Session (45 minutes): $150 (cash)
- Medication Management (30 minutes): $150 (cash)
- Routine Follow-up with Counseling (30 minutes): $100 (cash)
- Court Appearance: $600, plus $200 per hour for preparation, travel, and court time
- Disability Claim Paperwork: $50

MISSED APPOINTMENTS

If you do not show up for your appointment or cancel with less than 24 hours' notice, you will be charged $75 on the credit card on file for the appointment. This fee is not covered by insurance. Repeated missed appointments may result in termination of care.

PRESCRIPTION REFILLS

Prescription refill requests must be made during regular business hours. Allow three business days for processing. Please do not wait until your medications run out. A $50 fee will be applied for refills requested due to missed or canceled appointments.

RETURNED CHECKS

There is a $35 fee for any returned checks. We do not redeposit returned checks.

PAST DUE ACCOUNTS

If your account becomes overdue, we will take steps to collect the debt. You will be responsible for any collection costs, attorney fees, and court costs incurred.

MEDICAL RECORD REQUESTS

To request copies of your medical records, you must submit a written request and pay a fee. The fee includes a $20 retrieval fee, plus $0.50 per page for the first 50 pages and $0.25 per page thereafter. Payment is required before records are released.

WAIVER OF CONFIDENTIALITY

You understand that if your account is referred to an attorney or collection agency, or if we must litigate in court, the fact that you received treatment at our office may become a matter of public record.

By signing this agreement, you acknowledge and agree to our policies. To cancel this agreement, you must submit a cancellation request in writing.

Acknowledged and agreed by:

Patient Name: _____Patient Signature: _____

Date: _____

CONSENT FOR TREATMENT

If you are 18 years of age or older, you are consenting to your treatment. If you are the legal guardian or parent of the patient, you are consenting to treatment on their behalf.

Please note that your first visit is a psychiatric assessment. During this assessment, the provider will determine if they can best meet your mental health needs. If they are unable to do so, appropriate referrals will be provided.

Patient Name: _____Patient Signature: _____

Date: _____