PSYCHIATRY OF SCOTTSDALE, PLLC
LADAN GOBLE, MD

8800 EAST RAINTREE DRIVE, SUITE 155 SCOTTSDALE, AZ 85260 (P) 480-661-3877 (F) 480-661-3878

OFFICE POLICIES (effective February 1, 2018)

In order to be treated by **Dr. LaDan Goble**, you must complete this form.

FEES FOR SERVICE (*fees subject to change*)

Initial Evaluation (75min): **$395**
Follow-up (25min): **$170**
Medication with or without therapy (50min): **$270**

Please note: Fees for phone calls, letters and forms will be billed at a rate of $75 / 15minutes, or at the same rate for appointments, based on time needed by the physician.

Methods of accepted payment include**: EXACT CASH** and **CREDIT CARD ONLY**.

Appointments missed or cancelled less than 24 hours in advance will be charged at full rate of scheduled appointment time.

I authorize Dr. Goble to charge my credit card for any amount/fees owed, including past due amounts and attest that it is a valid and current credit card:

Card Type: ___________________ Card #: ____

Security Code: _______________ Expiration Date: _________________

Card Holder Name: ________________________ Card Holder Signature: ___________________________

I authorize use of credit card already provided on file ________________________________
(Payer's signature)

I understand that by signing this form, I agree to the terms and conditions of **Dr. Goble, Psychiatry of Scottsdale, PLLC**. I understand that Dr. Goble does **NOT** participate on any insurance plans (including Medicare/Medicaid) **AND** that full payment is due at the time of each appointment. I understand that I am responsible for submitting claims to my insurance carrier if seeking any reimbursement for services.

____ ___________________________
Patient /Guardian Signature **Date:**

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Patient/Guardian Printed **Name**