PSYCHIATRY OF SCOTTSDALE, PLLC
LADAN GOBLE, MD

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OFFICE POLICIES (*EFFECTIVE 10-1-2022*)

PLEASE SIGN AND SUBMIT FORM IN ORDER TO BE EVALUATED BY DR. GOBLE.

FEES FOR SERVICE:

(REMOTE OR IN-PERSON APPOINTMENTS AVAILABLE UPON REQUEST AND AVAILABILITY)

INITIAL EVALUATION (75 MIN):	$500
SESSIONS (50 MIN):	$350
SESSIONS (25 MIN):	$200
SERVICES (UP TO 15 MIN): *	$100

***CALLS OR REQUESTS OUTSIDE OF REGULAR BUSINESS HOURS FOR ESTABLISHED PATIENTS ONLY:**
PLEASE NOTE: CALLS, LETTERS, FORMS, RECORD REVIEWS, PRIOR AUTHORIZATIONS FOR MEDICATIONS WILL BE CHARGED AT A RATE OF **$100 PER 15 MINUTES,** OR SAME RATE AS SESSIONS, BASED ON THE TIME REQUIRED.

CANCELING OR RESCHEDULING POLICY (EFFECTIVE 10-1-2022):
-CANCELLATIONS LESS THAN **2 BUSINESS DAYS (48 HRS)** WILL BE CHARGED **100% OF SESSION TIME**.
-**NEW EVALUATIONS** REQUIRE **50% PAYMENT** AT TIME OF SCHEDULING, AND **FULL PAYMENT 2 BUSINESS DAYS (48 HRS)** PRIOR TO APPOINTMENT.

I authorize Dr. Goble to charge my credit card for any amount/fees owed, including past due amounts:

Card Type: _____ Card #: _____

Security Code: _____ Expiration Date: _____ ZIP CODE:_____

Card Holder Name: _____ **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 the insurance carrier if seeking any reimbursement for services.

_____ _____

Patient Name: **SIGNATURE** **Date:**

_____

Patient Name: **PRINT**