VAUGHN L. MANKEY, M.D.
Child, Adolescent, and Adult Psychiatry

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FEES/PAYMENTS

Dr. Mankey will discuss his fee schedule with you directly. Payment is due at the time of your appointment. Cash, checks, and major credit cards are accepted. Patients are responsible for any charges incurred due to returned checks or problems with credit cards. There will be no charge for business calls of less than 5 minutes. Telephone calls of over 5 minutes will be charged at the same rate as for sessions in the office. Completion of forms, letter-writing, record review, and other time required outside of sessions will be billed in 15-minute increments according to the typical rate.

Appointments cannot be scheduled if account balances exceed $450 (except in urgent situations). Accounts that are over 60 days past due may be referred to a collection agency. For minors, parents and/or guardians are responsible for all payments. Fees are subject to change, but all changes will be discussed before they go into effect.

INSURANCE

Dr. Mankey does not contract with any insurance company's directly. However, some insurance companies have "out-of-network" benefits, which will pay a portion of the cost of psychiatric evaluation, psychotherapy, and medication management after you have satisfied your deductible. If you plan to use this benefit, please check with your company regarding the availability of out-of-network benefits on your plan and the portion of expenses covered prior to your first appointment. Dr. Mankey will be happy to provide you with a receipt with the required information you will need as you submit any necessary forms to your insurance company. Once you submit your paperwork, any reimbursement the company provides you will be sent directly to you. Dr. Mankey does not submit any claims directly to companies. Payment is always required at the time of service - even when using out-of-network insurance benefits. You are responsible for all charges.

If you file a claim with your insurance company, they will access confidential information about you and/or your child. This may include diagnosis, severity, treatment plan, and any other information the company determines is relevant. Many companies may require this information prior to initiation of treatment and may seek to involve themselves in the management of your treatment.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THESE TERMS.

Patient or Guardian Signature: _____

Printed Name: _____ Date: _____

Relationship to Patient (if applicable): _____