RAJ SHIWACH, MD PA

941 YORK DRIVE SUITE 200
DESOTO, TEXAS 75115
P: (214) 884-5601F: (214) 452-3060

Contact and Consent for Evaluation/Treatment

I, _____, ("Client/Guardian") request treatment for myself at Raj. Shiwach, MDPA. may include diagnosis, evaluation, and treatment for any medical, emotional and behavioral problem, which may be found to exist.

Liability
In consideration of services rendered, Client agrees to hold Raj. Shiwach, MDPA blameless for any liability due to an accident, illness, injury, or incident, which may occur to Client while receiving outpatient services. Client also agrees to hold Raj. Shiwach, MDPA free from all liability for any losses through fire or theft. Client agrees, if hospitalization or extensive medical care Raj. Shiwach, MDPA to assist the client in obtaining appropriate medical attention. Further, the family, guardian, or Client is needed; that permission is hereby given to any agent of will assume all liability for any medical expenses, hospital care, or other expenditures without liability to Raj. Shiwach, MDPA

Financial Responsibility
Client and/or financially responsible party have been informed that she/he is financially responsible for services received at Raj. Shiwach, MDPA, unless payment is otherwise assured. The Client and/or financially responsible party have been further informed of all applicable co-pay fees. If, for any reason, your insurance company fails to pay any portion of the amounts we billed, you will be responsible for the balance and will be billed accordingly. All co-pays and deductible are due at the time of service. We charged $250-$350 for the initial doctor's appointment. Continue therapy, including medication management follow-ups, will be a charge of $80-$175.00. It is agreed that Client will provide Raj. Shiwach, MDPA with a permanent contact address and telephone number.

Returned checks are assessed a $35.00 fee. You agree to pay your bill within 10 days of receipt. If payment is not received within 90 days, your account will be turned over to collections. We have the option to pursue all lawful collection procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

Cancellations
We see all patients on an appointment basis. If you are unable to keep your scheduled appointment, please cancel as soon as possible so your allotted time may be given to another patient. We reserve the right to charge for missed appointments no called within 24 hours. The charge is $50.00 billed to you, not the insurance. Continued missed appointments may cause patient termination.

Records
Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or parent) release of information form. Records are copied at $40 plus postage and billed directly to you. Please allow two weeks for this request to be processed.

Letters
Letters and forms are often requested by patients (or their parents) to be sent to schools, employers, etc. You will be charged a letter writing fee for this service, minimum of $40.00. We do not complete forms until the $40.00 fee is paid. Please allow two weeks for this request to be processed. .

Telephone Calls
Your calls are welcome and we will return them promptly during business hours. Telephones will be answered from 8AM to 12PM and from 1PM to 5PM. If the operator is unable to answer your call, please leave a message on the voicemail box. The voicemail is checked 3 times a day and your call will be returned within 24 hours. When leaving a message, please leave your full name, a good call back number and a brief message. If you need to make an appointment or need medicine

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refill, please call during our business hours. Should you need to reach someone other than a provider, please listen to the options and dial that extension. If you have an emergency, please call 911 or go to the nearest emergency room.

Prescriptions
To prevent error and to maintain insurance and healthcare standards most prescriptions cannot be called in to the pharmacy. A charge of $10.00 for prescriptions that are misplaced lost or not filled in the 21 day time frame for controlled substances. You must return the expired prescription and pay the fee by check or cash.

Termination
Clinic policy states that the third appointment that is not kept and/or follow up with in four months will be regarded as termination of treatment on the part of the patient/client, unless we as a team have decided otherwise. If you fail to comply with treatment recommendations termination is non-negationable.

Confidentiality
I have further been assured that any information, knowledge, or records associated with said Client are subject to release only by my informed and written consent or by a court order, except in instances of medical emergency or suspected child or elder abuse or neglect. Your confidentiality and privacy are protected by the following Federal guidelines: Code of Federal Regulations (CFR 42 Part2) and the Health Insurance Portability and Accountability Act (HIPAA).

Discrimination Policy
No person will be discriminated against on the basis of gender, race, religion, age, national origin, disability (mental of physical), sexual orientation, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected. A person's economic condition and financial resources may be considered in admission criteria, but economic condition will not affect the services once an individual is admitted.

By signing this document, Client acknowledges that she/he understands the policy contained herein, and that if at any time there are questions, Client may return to a Raj. Shiwach, MDPA staff member for an explanation.

_____ (*please initial)*. Consent for treatment is made with informed consent, and as such, consent may be revoked and services discontinued at any time. By signing below, Client acknowledges she/he has read the above information and fully understands
its contents.

_____ _____
Patient Signature Date

_____ / _____
Financially Responsible Party Signature/Relationship to Patient Date

_____ _____
Staff Signature Date