BETHESDA PSYCHIATRY
Pavan Segal, M.D.

CHILD AND ADOLESCENT PATIENT REGISTRATION AGREEMENT

- I/We understand that the initial meeting is for the purpose of evaluation and to determine if a working relationship with Dr. Segal can be established.
- I/We understand that Dr. Segal is in solo private practice and does not share clinical responsibilities with other clinicians in the office suite.
- I/We agree to pay in full on or before my first visit and each visit thereafter. Dr. Segal does not participate with any insurance companies.
- A receipt is provided at each visit, and can be submitted to an insurance company for possible reimbursement. I/We understand that some procedures, such as, but not limited to, missed or late appointments, preparation of reports, and extended telephone discussions, may not be covered by any insurance company and are my/our responsibility.
- I/We clearly understand and agree that I/we am/are charged directly and I/we am/are personally responsible for payment of all services rendered to me (or the minor for whom I/we am/are responsible) in Dr. Segal's office.
- I/We agree that if I/we default on payment, I/we will pay collection costs, attorney's fees, and all court costs resulting from collection actions.
- I/We agree that if I/we am unable to give at least 24 hours notice of cancellation prior to my/my child's scheduled appointment time, I/we will pay a $150 cancellation fee. I further understand that if an appointment is missed without any notice, I/we will be charged the full and usual fee for that missed appointment.

☐ *I have read the Patient Registration Agreement*

☐ *My signature below indicates that I both understand and agree to this Agreement.*

_____

Parent or legal guardian signature

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