

Psychiatry of Tulsa P.C.

Patient Treatment Agreement

SOME MENTAL HEALTH DRUGS CAN BE HABIT FORMING – You may receive certain prescription drugs for your mental health diagnosis that can be habit forming. The medication is indicated to increase your level of functioning, allowing you to participate in activities to improve your quality of life. In order to protect our patients, Dr Sokkar and Staff, require that you observe the following rules, They are for you protection.

Medication Policies

I agree that the medication will be stopped, should my functional ability does not increase, or should it decrease, or I should be found to be misusing the medication in any way. Any prescription medication that is lost, misplaced, or stolen will not be replaced. Over – utilization of these medications will not be tolerated and a prescription will not be filled early for **ANY** reason. I will agree to taper or wean the medication when Dr. Sokkar feels it is appropriate. **I will not share or sell my medication with anyone. Not only is it a violation of the law, it could be dangerous. All medication will be taken as prescribed, If I feel that my dosage needs to be changed I will discuss this with Dr. Sokkar at my next appointment so the changes can be made accordingly.**

I understand that some medications should not be mixed with my behavioral health medications, therefore I agree not to obtain medication from any doctors, pharmacies, or other sources without discussing it with Dr. Sokkar.

Refill:

Refills will be done at your appointment time.

Patient Appointments: You must keep your scheduled appointments. **I understand that it is my responsibility to check the appointment card at the time that it is issued to verify the proper date and time are listed on the card. Dr. Sokkar will not waive a missed appointment fee because of an error appointment day. I understand it is my responsibility to remember my appointment.** All appointments are scheduled most often 28 to 30 days, there will be no walk-ins allowed. If patients come outside of the 30 days, medication may be decreased at the doctor's discretion. 24 hour notice is required for cancellations or a 25.00 no show fee will be added to your account.

Financial Policy

payment in full is due at the time of service, no partial payments accepted.

One form of payment as in cash, card, or check can be made at that visit.

We accept the following forms of payment

Cash, Personal Checks, Visa, MasterCard, Discover and American Express.

Due at the time of service: Non-Insured patients must pay in full for all at time of service. Patients presenting insurance must pay co-payment, co-insurance unmet deductible amounts, unpaid account balances, and or fees for non covered services, If co-payment, co-insurance amounts are not paid at the time of service your account will be charged a billing fee.

Insurance Filings: as a courtesy will file most, but not all, valid medical insurance. We will file two insurances (Primary and Secondary) for medical claims. Claims are sent electronically and by US postal service.

Primary Insurance: If we have not received a response within 45 days, the amount due from insurance. It then becomes the patients responsibility. Payment from the patient is due, In full, 30 days from notification. If the patients insurance pays Psychiatry of Tulsa, PC we will refund payment to the patient appropriately.

Past Due Balances: Amounts billed after initial insurance response are due within 30 days. If we have not received balance due within 30 days of the first statement a collection fee of 30 % will be added to the balance and balance will be assigned to a collection agency.

Right to Terminate Treatment

In certain rare circumstances, our clinic may reserve the right to terminate your treatment. In the event of misuse of prescriptions or in the case that your treatment is no longer seen as therapeutic, such that our options are maximized and further rapport and agreement in your care is compromised, then we may terminate our relationship. We also reserve the right to terminate your privileges as a patient in the event that you become non-compliant with our polices and procedures.

I voluntarily give my permission to Dr. Hazem Sokkar as he may deem necessary to provide Mental Health services to me. I understand by signing this form, I am authorizing him to treat me for as long as I seek care or until I withdraw my consent in writing.

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of the Patient Agreement and financial Policy. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement and Financial Policy. A photocopy of this document has the same effect as the original.

Signature of the Patient or Patient's Legally Authorized Representative

Date