HAGANhealth
HEALTHY MIND. HEALTHY BODY. HEALTHY CHOICES

# STATEMENT OF CHARGES

*I understand that the following represent Dr. Hagan's charges for outpatient mental health care.*

**Sessions with the Physician**
Initial psychiatric evaluation: 40-50 minutes, $225
Medication Management visit: 10 minutes, $75
Medication Management with psychotherapy: 20- 30 minutes, $100
Psychotherapy: 30 minutes, $100
Psychotherapy: 50 minutes, $200
Phone consultation: $50 for 15 minutes; $50 each additional 15 minutes
After hour medication management: $50
Missed appointments or late cancellations: $50 per event

**Session with Therapist**
Initial evaluation: 60 minutes, $225
Therapy Session: 60 minutes, $130
Consultation: 60 minutes, $150
Case Management (Contact via telephone to client or on behalf of client with client consent): 60 minutes, $150
Missed appointment or late cancellations (cancellation within 24 hours of appointment): Full Fee

**Administrative Fees**
Kasper request and review: $20
Urine drug screen: $25
Legal documentation: $400/hour prorated
Legal conference: $400, then $400/hour prorated
Independent medical evaluation: 2 hours $500
Disability forms: $400/hour prorated (FMLA, Short term disability, Long term disability)

******When you make an appointment you are "renting" a time slot. The rent is due whether you keep the appointment or not, unless the appointment is cancelled 24 hours in advance of your scheduled time. NO EXCEPTIONS are made for illness or other special circumstances.***

***ALL PAYMENTS MUST BE MADE AT TIME OF SERVICE***. We accept cash, credit card or check. We will give you an invoice upon request to use for reimbursement from your health savings account.

I understand that if I choose to use insurance, I will be required to assign the insurance benefits to Terry M. Hagan, M.D. I understand that Hagan Health does not file secondary insurance. I understand that I am responsible for any deductible or co-payment at the time of service.

I further understand that if the office is unable to collect from my insurance company after reasonable efforts are made for any services performed, I will owe the remaining balance and will be responsible to contact my insurance company for any further negotiation or reimbursement.

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Patient Signature Date

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