Siyan Clinical Corporation
480 Tesconi Circle, Suite B
Santa Rosa, CA 95401
(707) 206-7268 · Fax: (707) 206-7254

Fee Schedule & Payment Agreement

Siyan Clinical Corporation is committed to providing you with the best possible care, and we welcome our patients to discuss our professional fees at any time. Our patient's clear understanding of our Fee Schedule & Payment Agreement is important to our professional relationship.

- All patients are required to complete the below forms prior to their first appointment.
  - Patient Registration
  - Fee Schedule & Payment Agreement
  - HIPAA and Privacy Form
- Co-payments and deductibles are due at the time of appointment.
- Acceptable forms of payment: cash, checks, Visa, MasterCard, American Express, Discover, and PayPal

Initial: _____

Standard Out of Pocket Fee Schedule:

1.	Initial Psychiatric Evaluation:	$250.00 (50 Minutes)
2.	Suboxone Maintenance Initial Evaluation:	$300.00 (50 – 60 Minutes)
3.	Medication Management:	$150.00 (20 – 45 Minutes)
4.	Medication Management with Psychotherapy:	$200.00 (45 Minutes)
5.	Psychotherapy by Psychologist	$125.00 (45 – 60 Minutes)
6.	Urine Drug Screen	$25.00
7.	SUD Individual Counseling	$30 (30 Minutes) $45 (45 Minutes)
8.	SUD Group Counseling	$15.00 Per Group
9.	Group Psychotherapy with Psychotherapist	$60.00 (60- 90 Minutes)

*Urine Drug Screen may be required at every appointment. *

Initial: _____

Regarding Billing and Uncollected Checks:

- Any balance not paid by the patient's insurance company within **45 days** is deemed the patient's responsibility.
- Delinquent accounts over **120 days** will be reported to a collection agency.
- Failure of payment to an overdue account or failure to communicate may result in legal action, for which the patient agrees to be held responsible for all costs and fees associated with recovery of any amounts due.
- Checks that are returned to Siyan Clinical Corporation, uncollected funds or any collection reason may be subject to an additional fee of $50.00. (Subject to change)

Initial: _____

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Insurance:

Siyan Clinical Corporation is not authorized to change, or update patient insurance policies. Benefits are a direct contract between the patient and the insurance carrier. Any disputes of coverage are the responsibility of the patients to carry out with the insurance company. Siyan Clinical Corporation will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual & customary" charges, etc. other than to supply factual information as necessary. If you have questions concerning fees for service, it is your responsibility to have these answered prior to your appointment to minimize any confusion on your behalf.
Initial: _____

Insurance Authorization:

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

Initial: _____

My Financial Responsibility:

I understand that any balance due at the time of service is my personal financial responsibility for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

Initial: _____

Missed Appointment Fee:

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments $50.00. Please help us to serve you better by keeping scheduled appointments. Please note on the 3rd consecutive no show you will be charge $150.00 and your case will be closed. (subject to change)

Initial: _____

Urine Drug Screen:

A urine drug screen may take place at every visit per the providers discretion. The patient is responsible for the Standard Out of Pocket Fee if the patient's insurance does not cover the cost.

Initial: _____

By Signing my name below, I certify that I have read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding o the agreement with the above policies. I understand I am responsible for all charges not paid by my insurance. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

x_____ _____
Signature of patient or Guardian of minor/ disabled Date