A L I C E W . L E E , M D , A B I H M

Office and Professional Policies

As part of our working relationship, I would like to make clear the rights and responsibilities that we share. Please read the following carefully, return one signed copy to me and keep the other for yourself.

PROFESSIONAL QUALIFICATIONS: I am trained as a child, adolescent and adult psychiatrist. The process of training entailed four years of medical school, four years of adult psychiatry residency training, and three additional years of child psychiatry fellowship training. I also take 50 credit hours of continuing education every two years. As a result of my education, I am comfortable with providing psychotherapy and medication as needed.

THERAPEUTIC ORIENTATION: I believe that healing is both an art and a science. Healing requires an awareness of the spiritual, social, psychological and biological aspects of an individual and a physician who tailors the care to the unique needs of each individual. Positive changes occur when the patient and the physician work together cooperatively within a therapeutic relationship that aims to restore the patient to a healthy state of being.

CONFIDENTIALITY: All issues discussed in the course of therapy are strictly confidential. By law, release of confidential information is required in the event of potential suicidal or homicidal intent and child abuse.

EMERGENCIES: I am easily accessible by voice mail at 301-802-4474. In the event of an emergency and I am unavailable, please call an emergency hotline or 911. My practice is not able to provide continuous emergency service.

PAYMENT POLICY: Please take a moment to see the "CPT Codes of Services/Fee Schedule" as it tells you exactly what services you can be charged for and their rates. A bill based on these rates will be provided to you each month. Payment is due at the time of the appointment. **Because time allotted for scheduled appointments has been reserved exclusively for you, all cancellations or missed appointments will be billed in full.** A late fee of $20.00 is added per month for payments received after the 25th of each month. Also, a charge of $30.00 is added for checks that are returned due to insufficient balances. The patient or legal guardian is directly responsible for payment to the physician. It is the patient's choice and responsibility to submit the bill to an insurance company for reimbursement. Neglect of payment may require collection by a third party, such as an attorney. If such services are required, the patient will be responsible for the cost of these additional services, including the attorney fees.

CONSENT: I have read the above information and have clarified any questions I have. I agree to the above stated terms.

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Patient/Guardian Printed Name/Signature/Date

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