Patricia M. Gentile, MD
Adult, Child & Adolescent Psychiatry
1115 Bethel Road Columbus< OH 43220
Tel 614.228.7275 Fax 614.228.7289

Name _____ Date of Birth_____

Appointments and Fees

Psychiatric Evaluation $375 Child/Adolescent $350 Adults
(generally 1-1.5 hours; includes charting, etc..)
Minors must be accompanied by parent / guardian for evaluation and most follow ups

Med management	15 to 30 minutes	$115
Psychotherapy/ med management	30 to 45 minutes	$160

Phone Contacts / Letters Written, etc.
Any contact outside of a scheduled appointment (including contact with or for your insurance company) will be billed at the above rates.

Payments for services are expected at time of service by cash, check or credit card. I provide you with the necessary information so that you can bill your insurance company but will likely not be on any panels other than OSU. For those insured through OSU plan, I will accept a co-pay and bill insurance.

Cancellations and No-Shows

"No Show " Appointments will be billed to you at the full fee.
Cancellations with less than 24 hour notice will be billed to you at 25% of full fee unless there is an unusual emergency. Insurance will not reimburse you for these fees.

Confidentiality

Everything that takes place in treatment is confidential and may not be released without your expressed written permission. There are two exceptions to this; if you or your child becomes a danger to self or others; and if you or your child is involved in child abuse. In these situations I am legally bound to break confidentiality in order to protect all involved.

Emergencies and After Hours

My Voicemail (228-7275 x2) will be checked daily on weekdays and once on weekends. In event of emergency, please call 911 or proceed to your appropriate emergency room or urgent care. Riverside Hospital Behavioral Health also provides emergency services at 614-566-5056

I consent to psychiatric medical care provided by Dr. Gentile. I understand and agree with the policies described above. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered. If my account is more than 60 days in arrears, I authorize that pertinent billing information can be released to a professional service for purpose of collection of outstanding balances.

Patient Signature(or parent/guardian)_____ Date:_____