

**JOEL ELLISON, M.D.**  
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**Fee Schedule Effective 06/01/2017**

<b>Initial Evaluation (60 min.)</b>	<b>\$265.00</b>
<b>Follow-up Individual Session (50 min.)</b>	<b>\$200.00</b>
<b>Follow-up Family Session (50 min.)</b>	<b>\$200.00</b>
<b>Follow-up Individual Session (30 min.)</b>	<b>\$150.00</b>
<b>Telephone Contact to Monitor Medication (10-15 min.)</b>	<b>\$65.00</b>

*Welcome to my practice. Thank you for turning to me for assistance. This notice serves to summarize my office procedures and billing. Please let me or my administrative staff know if you have any questions or concerns.*

Please Take Note:

1. Payment is due at the time services are rendered.
2. If for any reason you are unable to keep a scheduled appointment, you are responsible for calling to cancel. You will be charged full fee for the missed appointment unless you give the required notice listed below.
3. Each session has designated time limits as indicated in the fee schedule above. If you are late for a session, that time is lost from your session.
4. I may discuss your treatment with another psychiatrist in order to provide coverage for any time period when I am out of town or otherwise unavailable.
5. There is no charge for brief phone calls, but extended phone consultations are charged for at \$65.00 per 10-15 minutes.

Insurance:

1. I do not participate in any insurance panels, therefore I will be an out-of-network provider. If your insurance plan requires a prior authorization before my psychiatric evaluation, please contact them to obtain the pre-approval before we meet.
2. If you request, my office staff can file your insurance claim forms for you on a monthly basis. The amount of reimbursement from the insurance company will depend on your policy.
3. Because insurance plans have become more numerous and complex in the past few years, it has become impossible for me to monitor the status of claims. Consequently, you are responsible to monitor your own insurance claims and must deal directly with your insurance company concerning any problems that arise regarding reimbursement.

**Please read and initial the following:**

- \_\_\_\_\_ I am aware of charges of \$35 for most paperwork to be filled out by a physician. This fee may vary per \$5 each additional page due to complexity of paperwork.
- \_\_\_\_\_ I am aware of a charge (full fee) for a missed appointment without a 24 hour notice for weekday appointments and 48 hour notice for weekend appointments.

Name: \_\_\_\_\_ Date: \_\_\_\_\_