R O Y   M .   S T E F A N I K ,   D O

P S Y C H I A T R Y

5675 STONE ROAD, SUITE 320
CENTREVILLE, VA 20120
(703) 830-1500

EMAIL: RMS23@GEORGETOWN.EDU
FACSIMILE: (703) 830-0001

Office Policies and Financial Agreement

Please read the following statements and sign your name below. I will be glad to discuss any policy with you or answer any question before signing. Upon request, a copy of this agreement will be provided for your records.

Payment in full is to be made when services are rendered. Payment may be in the form of cash, money order, personal check, VISA, or Mastercard. Checks are payable to "Roy M. Stefanik, DO." A statement of services and payments will be provided at the time of service.

Your insurance is a contract between you, your employer, and your insurance company. I am not a part of that contract and as a result, I do not file insurance forms directly for you. However, I will assist you in receiving reimbursement of fees from your insurance carrier by supplying the necessary information on the receipt statement at the time of your service. If additional information is required, I will assist you by providing it.

Bills for services rendered are your responsibility. Failure of an insurance carrier or other third party to pay for services rendered does not relieve you of your responsibility to pay me directly. Checks returned for insufficient funds are subject to a $35.00 processing fee.

All services are provided on an appointment basis. This time will be held for you and is not available for other patients. It is your responsibility to inform me if you will not be keeping an appointment. At least twenty-four (24) hours advance notice is required to cancel an appointment without charge. If I cancel your appointment, you will not be charged for the session.

A copy of the HIPAA (Health Information Portability and Accountability Act) compliance policy is available on request from the office manager or can be seen on my website www.fairfaxmentalhealth.com. I will be happy to answer any questions you may have about my privacy and confidentiality policy. Does the patient request a hard copy? ❑ yes ❑ no

Please note that Fairfax Mental Health is not a partnership. Each professional in this office is an independent provider and shares no responsibility or liability for the advice given to the undersigned unless requested to render a service.

I have read, accept, and agree to the above.

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Patient's Printed Name

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Patient’s Signature Date