Roxann Sangiacomo, M.D., P.A.
American Board of Psychology and Neurology
14150 Metropolis Ave., Suite 4
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(239) 768-6060 Fax: (239) 768-6242

PATIENT TREATMENT AGREEMENT

Welcome to Roxann Sangiacomo, M.D., PA Outpatient Services. We would like to assure you that you will receive the best possible care from our professional staff.

OFFICE HOURS: 9:00 – 5:00 Monday –Thursday and 9:00 – 2:00 on Friday

We are available in the office during these times.

EMERGENCIES: All non-emergency calls must be made during office hours. If you have an emergency outside of office hours, call the main office number and instructions for receiving emergency help will be available 24 hours a day by Dr. Sangiacomo or the Psychiatrist on call.

REFILLS: Please call the office for refills one week before your supply runs out. No medication refills will be available on weekends or after hours except in extreme cases. The Psychiatrist on call will not provide refills in most instances.

CANCELLATIONS: If you are unable to keep your scheduled appointment, **YOU MUST NOTIFY OUR OFFICE 24 HOURS IN ADVANCE or YOU WILL BE CHARGED FOR THE APPOINTMENT.** If less than 24 hours notice is given, we will attempt to fill the opening. If we are unable to fill the time appointment set aside for you, **YOU WILL BE CHARGED THE FULL FEE** for the appointment. Insurance Companies do not cover missed appointment fees.

LEGAL: Dr. Sangiacomo and her staff of Licensed Mental Health Counselors are available for in-office depositions. They are not available, nor will they appear in court for testimony regarding your case unless arrangements are made, outside of and prior to this initial agreement. By signing, you agree that this information has been formally conveyed.

Payment is due at the time service is rendered. We accept Cash, Check, Visa, Master Card and Discover. A $30.00 fee will be charged for returned checks.

"I, the undersigned, agree to treatment by the Providers in this office, and furthermore have read and understand the above office policies. I also acknowledge I have received a copy of these policies."

Patient Signature: _____ Date: _____