KIRA STEIN, MD, APC
433 N Camden Drive, Suite 600
Beverly Hills, CA 90210
TEL 310-529-6051 ◆ FAX 888-959-0148

FEE SCHEDULE & CREDIT CARD ON FILE AUTHORIZATION

UPDATED 11/19/2017

90 min Initial Consultation	**$650**
25 min Appointment	$250
45 min Appointment	$425
60 min Hourly Rate for:	$500
• 60 min sessions	
• Evaluation of Records (prorated)	
• Insurance Evaluation Services (prorated)	
• Disability Evaluation Services (prorated)	
• Reports and Letters (prorated)	
• Prior Authorizations and other Insurance-Related Documentation (prorated)	
Telephone Sessions - At provider's discretion:	
• 5-10 min	$65
• 11-20 min	$130
• 21-30 min	$250
In-Office Lab Collection & Administration	$65
Between-Visit Refills and Prescriptions	$20 for non-controlled prescribing
(if patient missed, postponed, or is overdue for scheduled visit)*	$40 for controlled prescribing
Unscheduled refills require doctors to take time to review patient records, decide if a refill is appropriate, document the reasons for the refill, and contact the pharmacy and/or patient. To avoid this situation, patients should address medication refill needs during scheduled appointments. All refill requests between scheduled appointments require at least 48 business hours advance notice.	
Document Production (electronic)	$0.35/page
Document Production (paper)	$0.45/page + postage

The above rates are subject to change.

I have read the above service fee schedule carefully. I authorize Kira Stein, MD, APC to keep my credit card information on file, to update the file as I provide new credit card information in the future, and to automatically charge my credit card on file for _____ as follows:
Patient Name

- ✓ For the initial consultation at the time of reservation, non-refundable if the initial appointment is missed or canceled with less than 48 **business** hours advance notice.
- ✓ For follow-up services rendered, products purchased, or for **any** missed or cancelled sessions with less than 48 **business** hours advance notice.
- ✓ For payments at the time of visit if I do not pay by cash or check at my visit.
- ✓ For any outstanding balance or bills and interest accrued.
- ✓ For the amount of each check that does not clear the bank, for whatever reason, plus a $38 returned check charge per incident.

CANCELLATION: This authorization is to remain in full force and effect until Kira Stein, MD, APC has received written notification from me of its termination in such time and manner as to afford Kira Stein, MD, APC and my financial institution a reasonable opportunity to act on it.

_____ _____ _____ _____
Date Full Name Signature Relationship to Patient

_____ _____
Billing Address (No, Street Name, State, Zip) Email Address

_____ _____
Cell Phone Number Home Phone Number

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OFFICE POLICIES – FINANCIAL GUARANTOR

PATIENT NAME: _____ FINANCIAL GUARANTOR NAME: _____

The following two pages include the office policies of Kira Stein, MD, APC. Please read them carefully:

■**INSURANCE & MEDICARE.** Kira Stein, MD, APC provides "out of network", fee-for-service care and does not contract or negotiate claims with insurance companies, MediCare, MediCal or other persons. As financial guarantor, you are agreeing that you are responsible for payment of patient's medical care regardless of the status of their claim. Any other financial arrangement must be made with Dr. Kira Stein prior to service. If patient is a MediCare beneficiary and wants to see Dr. Stein, they will need to sign a private contract, agreeing not to submit their visit receipts to MediCare. Please understand that MediCare does not reimburse for services conducted by Dr. Stein.

■**PAYMENT FOR OUTPATIENT AND OTHER SERVICES.** Patient initial visits require payment at the time of reservation, and are non-refundable if missed or canceled with less than 48 business hours advance telephone notice. Payment for all other services, including patient's follow-up visits, Laboratory fees, and administrative services, are always due at the time of service**.** We accept cash, VISA, MasterCard, American Express and Checks. Your credit card on file will automatically be charged at the time of follow-up visits or administrative services if you do not pay by cash or by check or another valid credit card.

■**CREDIT CARD ON FILE.** A valid credit card on file must be maintained.

■**RETURNED CHECKS.** Your credit card on file will be charged for the amount of your returned check plus a $38 fee.

■**OUTSTANDING BALANCES.** We prefer to spend time on clinical matters and caring for patients. Please understand that nonpayment for services provided or missed appointments is cause for termination of care. Your credit card on file will be automatically charged for outstanding balances not paid at the time of service. Accounts with balances more than 30 days past due may be charged 1.5% interest per month. Accounts with balances more than two months past due may be turned over to a collection agency and reported to credit bureaus.

■**AUTOMATED FOLLOW-UP APPOINTMENT REMINDERS.** Even if the patient has signed up to receive appointment reminders, technical errors occur, and they are still responsible for maintaining their own calendars. As financial guarantor, you will be charged for missed or late canceled appointments, even if the patient do not receive a reminder.

■**MISSED OR CANCELLED APPOINTMENTS OR PROCEDURES WITH INSUFFICIENT ADVANCE NOTICE.** Because our visits are by appointment only, when someone misses an appointment, it creates a missed opportunity for another patient to be seen.

- **Initial visits** require payment at the time of reservation. For the initial visit fee to be refunded, advanced cancellation telephone notice of **at least 48 business hours** is required. The initial visit fee is non-refundable and non-transferable to a rescheduled initial visit time if the missed visit or cancelation was given less than 48 business hours notice.
- **Follow-up visits** require advanced cancellation notice of **at least 48 business hours** to avoid being charged the full fee of the scheduled visit. Your credit card on file will automatically be charged at the regular rate for any sessions that are cancelled without at least 48 business hours notice.
- **Example**: A follow-up appointment starting at 9:00am on Monday needs to be cancelled before 9:00am on the Thursday before in order to avoid being charged (or to get refunded, if it is an initial visit).

■**DISCONTINUATION OF TREATMENT**: Typically, a patient decides when to end treatment, which may be done at any time in person, in writing or by phone. We can also discontinue treatment at any time. When the practice discontinues treatment, the most common reasons can include: Failure to pay for services rendered, nonpayment of missed appointments or services, cancelling or missing appointments too often, non-adherence with recommended treatment and follow-ups, and/or more specialized or intensive care is needed than what is available at Kira Stein, MD, APC.

■CLINICAL CONCERNS*:*

- **PRESCRIPTIONS AND RESCHEDULING.**
  When to Get Prescriptions. Prescriptions and refills take place during regularly scheduled appointments, as refills prescribed are meant to last until the next visit. Please address any medication prescription needs with your doctor during the time of your visit and whenever you cancel and reschedule an appointment.
  Refills Between Appointments While Overdue for Follow-Up. On the rare occasion when refills are needed in between appointments, this usually means patients are overdue for follow-up, even if they have rescheduled. In such cases 48 business hours is required to process the patient's request and your card will be charged $20 for non-controlled prescriptions and $40 for controlled prescriptions to cover clinician time and care taken to review the patient's chart, consider the patient's request, and contact the pharmacy, and if necessary, check other databases, etc.
- **HANDWRITTEN PRESCRIPTIONS.** Rarely, certain pharmacies require hand-written refills for certain, specific medications that cannot be called in, electronically submitted, or Faxed. As a result, these prescriptions need to be filled during appointments, preferably scheduled at least 4 weeks in advance and during regular office hours. This avoids a patient suddenly needing a handwritten medication at a time while the doctor is out of the office or on vacation.
- **ROUTINE CLINICAL QUESTIONS BETWEEN VISITS.** For routine clinical concerns and questions, the patient should leave a message on Dr. Kira Stein's routine, non-urgent voice-mail at (310) 529-6051. The patient will be called back as soon as possible, usually by the next business day. Note that messages will not be checked on holidays, weekends or after 4:00pm on weekdays. Non-urgent calls may be returned by an assistant who will maintain the practice's confidentiality procedures.
- **URGENT/EMERGENT SITUATIONS.** Call (310) 529-6051 and listen to the entire outgoing message. Follow the instructions on how to reach the covering doctor urgently. If you do not receive a callback within 60 minutes, please assume technical issues and call again. If your situation is an emergency (e.g., life-threatening) such that you cannot wait for the covering healthcare provider to return your call, then call **911.**
- **WHEN DR. KIRA STEIN IS ON VACATION.** The outgoing message on (310) 529-6051 will leave instructions on how to contact the covering healthcare provider.

- I agree in the event of non-payment to bear all the costs of collection, court costs, and legal fees as are required.
- I hereby acknowledge full responsibility for payment of fees and costs, per Kira Stein, MD, APC's fee schedules that are in effect at the time service is rendered, understanding that rates are subject to change at any time.
- CANCELLATION: My authorization to charge my credit card on file is to remain in full force and effect until Kira Stein, MD, APC has received written notification from me of its termination in such time and manner as to afford Kira Stein, MD, APC and my financial institution a reasonable opportunity to act on it.
- I have read and understood and I agree with the foregoing, and agree to the above policies.
- A facsimile or photocopy of this signature is as valid as the original.

_____	_____	_____
DATE	PATIENT NAME	PATIENT DATE OF BIRTH

_____	_____	_____
PRINTED NAME OF FINANCIAL GUARANTOR	SIGNATURE OF FINANCIAL GUARANTOR	PHONE NUMBER OF FINANCIAL GUARANTOR

_____
FULL RESIDENTIAL ADDRESS OF FINANCIAL GUARANTOR (No, Street, Apt, City, State, Zip)