Luminox Healthcare Services, LLC
Practice Policies and Procedures Handbook

Effective Date: [Insert Date]

BILLING, FEES, APPOINTMENTS, NO-SHOWS, TARDINESS, AND CANCELLATIONS

1. **Cancellations:** Please cancel or reschedule appointments at least **24 hours in advance**. Cancellations with less than 24 hours' notice or missed appointments will be charged the full visit fee.
2. **Pre-Appointment Requirements:** New patient consents, intake questionnaires, and insurance information must be completed **24 hours prior** to your appointment.
3. **Grace Period:** You have a **15-minute grace period** before being considered late. Arrivals after 15 minutes may be marked as a No-Show and charged the full fee.
4. **Late Arrivals:** Arriving late within the grace period may shorten your session time.
5. **Session Length:** Appointment durations range from **15–60 minutes** depending on your treatment needs. Requests for extended sessions must be arranged in advance.
6. **Returned Payments:** A **$20 service charge** applies to any returned payment.
7. **Credit Card Payments:** Cash-pay clients using a credit card will incur a $5 processing fee.
8. **Time Zone:** Appointments follow **Eastern Standard Time** regardless of your location.
9. **Insurance Verification:** You are responsible for verifying telepsychiatry benefits with your insurance. If your visit is not covered, you will be billed the self-pay rate.
10. **Outstanding Balances:** All balances must be paid at the time of your appointment.
11. **Deductibles:** If your deductible has not been met, you are responsible for the visit cost.
12. **Credit Card Authorization:** You authorize Luminox Healthcare Services, LLC to bill charges for which you are financially responsible, including late fees.
13. **Information Updates:** Notify us promptly of any changes to your payment method or contact details.

DOCUMENTATION & PAPERWORK FEES

- Disability or community resource forms: **$50–$100 per occurrence** (eligible only after 6–9 months of consistent treatment).
- Work, school, or other letters: **$50–$100 per request**.
- Turnaround time for documentation: **3–5 business days**.
- Permanent disability paperwork is **not** completed; diagnostic or treatment summaries can be provided.

SELF-PAY RATES

- **$225** – Initial Psychiatric Evaluation
- **$125** – Medication Management Visit (with refills)
- **$90** – Routine Follow-Up
- **$145** – Controlled Medication Follow-Up
- **$250** – Suboxone Induction
- **$150** – Monthly Suboxone Maintenance
- **$125 per 20 minutes** – Telephone Consultation (non-scheduled clinical calls)

SCHEDULING & ATTENDANCE

1. Monthly or biweekly follow-ups may be required for medication refills.
2. Three No-Shows may result in discharge from care.
3. You are responsible for setting up your preferred appointment reminders.

MEDICATION REFILLS

1. Refills outside of scheduled visits incur a **$35 fee**.
2. Medication adjustments require an appointment.
3. Report any side effects promptly.

TELEPHONE & EMERGENCY CONTACT

- For emergencies, call **911** or **988** (Suicide and Crisis Lifeline).
- Non-emergency calls outside scheduled visits may be billed at consultation rates.

ELECTRONIC COMMUNICATION & TELEHEALTH

- Communication about scheduling may occur via secure patient portal messaging.
- Clinical discussions will not occur via unsecured email or text.
- Telepsychiatry sessions are conducted through HIPAA-compliant platforms.
- You have the right to withdraw telehealth consent at any time.
- All confidentiality laws apply to telehealth.

SOCIAL MEDIA POLICY

- We do not accept friend or contact requests from clients on personal social media accounts to protect confidentiality and maintain professional boundaries.

TERMINATION OF SERVICES

Treatment may be terminated if:

- Appointments are repeatedly missed.
- There is non-compliance with treatment (e.g., lab work, therapy, UDS).
- A higher level of care is needed.
- There is aggressive, abusive, or unsafe behavior.
- Payments are repeatedly missed.

If terminated, referrals to other providers will be offered. If no appointment is scheduled for 90 days without prior arrangement, the clinical relationship will be considered ended.

By signing below, I acknowledge that I have read, understood, and agree to the terms in this Handbook.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____