Amanda Sun, M.D.
Child, Adolescent and Adult Psychiatry
1122 Kenilworth Drive, Suite 100
Towson, MD 21204
Phone/Fax: 410-881-4639

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Legal Guardian/Parent (if applicable): _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ Work: _____
Cell Guardian/Parent 1: _____ Cell Guardian/Parent 2: _____
Referral Source: _____
Primary Care Physician/Address/Phone: _____
_____
Pharmacy/Address/Phone: _____
_____
Insurance: _____ Member ID: _____ Group: _____

Are you/your child enrolled in Medicare? [ ] Yes [ ] No
Dr. Sun has opted out of Medicare. Therefore, those individuals with Medicare who wish to see her cannot submit claims to Medicare and must sign an agreement stating understanding of this.

Responsible Party: Who is responsible for the account?
Name: _____ Relationship to patient: _____
Address: _____
Phone: _____ Cell: _____

Financial Policies (please initial):
_____ All fees are due at the time services are rendered. Payment is accepted in the form of check, cash and credit card.
_____ A detailed receipt will be provided with proof of payment and diagnosis/treatment codes to facilitate reimbursement to the client from the insurance company. Client understands that he/she will seek reimbursement from the insurance company.
_____ Fifty percent of the appointment fee will be charged for missed appointments without 48 hours' notice of cancellation. This fee will be collected at the time of the next appointment.
_____ Standard session fees will be charged for all scheduled phone calls with parents, patient, school, etc. that exceeds 15 minutes.
_____ There is no fee for standard school forms/medication forms, treatment plans, brief letters. In the event a lengthy letter/treatment summary/form is needed a fee commiserate with time spent will be charged.
_____ Standard fees will be charged for time spent and travel time if it is necessary for M.D. to attend a school/IEP meeting or testify in court.

Consent to treatment: With my signature below, I give permission and consent to Amanda Sun, M.D. to provide psychiatric services to myself/my child for whom I have legal custody and power of consent for medical treatment.

Signature: _____ Date: _____