

JOSEPH M. SHARPE, M.D.
General Office Guidelines
Tel: 615-284-3850

Patients are seen by appointment only. As we make every effort to remain on time according to schedule, you are asked to be on time as well. Visits typically last between fifteen minutes and one hour depending on the individual patient's needs. Payment in full is required at the time of service.

Should you arrive late for your scheduled appointment, we can meet for the remainder of the scheduled time, but probably not the full time out of respect for the next patient.

Telephones are either answered in person or via service throughout each business day, and Michelle, my assistant, is also happy to communicate via email at michelle.moon@sth.org as many people find that more convenient.

Because we only schedule one patient per time-slot, missed appointments will be charged the full fee and must be paid prior to rescheduling. Should you find that you need to cancel an upcoming appointment, we require a minimum notice of 24-hours. Our answering service is available when the office is closed and messages should be left with them for any cancellation.

Due to the unavailability of patient records, medications will not be refilled outside of office hours, including weekends and holidays. We strive to make sure patients have sufficient refills to cover from one appointment until the next. Should you need a refill prior to an appointment, depending on the type of medication, we will only fill enough until your scheduled appointment. Early refills of medication will not be approved under any circumstance.

Initial appointments last approximately one hour and the fee is \$300. Follow-up visits range from 15-60 minutes depending on patient's preference. Fifteen minute medication management visits are \$90, a 30-minute visit is \$150, a 45-minute visit is \$225, and a one-hour counseling session is \$300. Payment of these fees is required at the time of service.

This information should cover most of the questions that may arise. It is intended to familiarize you with how the office operates so that we may work together with you in a manner of mutual respect.

AGREEMENT: By signing below, I am acknowledging my willingness to participate in the treatment process. I further acknowledge that I have read, understand and agree to all listed office policies. I agree to pay for all charges incurred as a result of my treatment, and understand that a delinquent account is subject to being turned over to a collection agency if not paid in a timely manner. I also understand that I will be charged for cancellations made with less than 24 hours' notice or in the event I fail to keep my scheduled appointment.

Patient Signature

Date