William Shevin M.D., D.Ht.
50 Applewood Drive
Woodstock, CT 06281
www.drshevin.com
tel: (860) 928-4040
fax: (860) 928-0733
email: drshevin@drshevin.com

FEES AND POLICIES

Initial Consultation (1.5 - 2 hr.)	$415.00
Initial Consultation (1 hr.) ………….................................…..	$260.00
Standard re-visit (1/2 hour) ....…	$130.00
Extended re-visit (45 min.) ....…	$190.00
Intermediate re-visit (15 min.) …………………………….	$80.00
Brief visit (time and complexity dependent) ……………..	$50.00
"Escrow Fund" Voluntary Contribution . ...….....	$1.00

The Escrow Fund is created by my taking a dollar from each charge, and once a month transferring that amount to a homeopathic organization of my choice. Organizations to whom I have contributed from this fund include the National Center for Homeopathy, the Homeopathic Pharmacopoeia Convention of the United States, the Homeopathic Community Fund, Physicians for Human Rights, and Doctors Without Borders. Your contribution is voluntary and if you do not wish to make it, please let me know. You may increase your contribution.

Medical services are highly individualized and the benefits of treatment depend on a thorough understanding of your case. In complicated cases more than the usual amount of time may be necessary to arrive at this understanding, and the charge may therefore be greater.

APPOINTMENTS: An appointment is an agreement between us. I am responsible to be present and to provide services to the best of my ability, or inform you otherwise. You are responsible for keeping the appointment, or giving me at least 24 hours notice of cancellation (3 working days in the case of a first visit.) I do not overbook appointments, and reserve the right to charge for missed appointments without adequate notice of cancellation.

PAYMENT: Payment is required at the time of service unless other arrangements have been made in advance. We will submit a claim to your insurance carrier, which will then reimburse you according to the terms of your contract. I am not a Medicaid provider, and therefore cannot bill to or receive payment from Connecticut Title 19. I ask that Medicare patients pay at the time of service - I will, as required by law, submit the claims for your visit to Medicare. I do not accept "assignment" except by special arrangement. In case of financial hardship, I will endeavor to work out a payment plan with you.

OVERDUE ACCOUNTS: If your account becomes more than 90 days overdue, I will contact you to arrange a payment plan. I understand that circumstances change, and am very tolerant in terms of payment if I can trust that you are acting in good faith. For me, that means that you will inform me that you are not able to pay in full and will arrange a payment plan, and then follow that plan.

AFTER HOURS COVERAGE: I am not able to provide "primary care" at this time. I will not always be available in emergencies, and I do not admit patients to hospitals. I will endeavor to have another homeopathic physician available to you when I am away, but distance from that practitioner may make providing emergency services problematic. In the case of an emergency you may need to go to the hospital emergency department. Please use your judgment in this matter.

TELEPHONE or EMAIL CONSULTATION: I will generally not charge for a telephone or email consultation when it is short, and involves a simple judgment or a quick follow-up to a previous visit. Otherwise, I reserve the right to charge for consultations made over the telephone, or via email, based upon time and the complexity of the problem. These will generally not be reimbursable through your insurance.

RIGHTS: You have the right to be treated with courtesy, respect, and dignity, and to understand my analysis of your problems and the treatment plan. Please feel free to ask any questions necessary to achieve this understanding. I sometimes have health professionals and medical students as visitors or in training, who wish to be exposed to or learn homeopathic medicine. You have the right to refuse such observation. Your medical records are confidential and I will require a written release from you before I give them to any outside agency. Should I wish to prepare journal articles or give talks at professional meetings utilizing information regarding your case and your treatment, neither your name nor address will be used.

Your signature below indicates that you have read and have understood these polices:

Signature: ____________________________________ Date: ______________