Daniel R Garza, MD, PA
3131 Eastside St
Suite 415
Houston, TX 77098

This document contains information about professional services and business policies. Please read it carefully and feel free to bring up any questions you have. When you sign this document, it will represent an agreement between you and Dr Garza.

Dr Garza's office telephone number is **281-610-8190.** Routine messages will be answered at Dr Garza's earliest convenience during and after business hours. When you leave a message, please include a phone number that he can reach you at after 5:00 pm.

If you have an emergency, please call his office telephone number at **281-610-8190**. In an emergency, if you do not hear back from Dr Garza within 1 hour, please call and leave a second message. If you cannot wait for a return call, you should go to your nearest emergency room.

Professional Fees:

Initial Assessment	$400
Individual Therapy (45-60 minutes)	$400
Medication Management with	
Supportive Therapy (45-60 minutes)	$400
Medication Management (20-30 minutes)	$200
Non-emergency, after hours telephone calls	$25 per 5 minutes
Paperwork	$350/hour

Insurance:
Dr Garza does not participate in most managed care plans, but he will provide you with the appropriate documentation to file for out of network insurance claims for your reimbursement. Dr Garza currently accepts Aetna Health Insurance.

Billing and Payment:
Patients are responsible for paying at the time of service. Dr Garza accepts cash, checks, Visa, MasterCard, and American Express, or a combination.

Missed Appointments and Cancellation Policy:
Patients are responsible for scheduled appointments. TWO FULL BUSINESS DAY'S notice of cancellation is required, otherwise you will be charged for the time. If there is less than one full business day notice, Dr Garza will not charge you IF he is able to schedule another patient.

By signing below, you are acknowledging receipt and agreement of these policies. A copy will be given to you for your records upon request.

_____
Patient Name (print)

_____   _____
Patient Name (signature)   Date