COMMUNITY AND LONG-TERM CARE PSYCHIATRY, L.L.C.

10004 Kennerly Rd, Suite 362B, St. Louis, MO 63128; Phone 314-525-5050; Fax 314-525-5072

NEW PATIENT INFORMATION FORM

All information is subject to the Consent to Release PHI and the Notice of Privacy Practices

PATIENT INFORMATION

Today's Date:________________

Name:____ Date of Birth:___________

Last First Middle Initial

Address:____

Street Address City State Zip

CONTACT INFORMATION: (Please circle preferred method of contact for appointment confirmation.)

Do you authorize us to leave a message on your voice mail / answering machine? Check one;____Yes,_No

Home phone: __ ___ ___ ___ _ _Work phone:______________________________

Cell phone: _________________________E-mail: ______________________________

INSURANCE INFORMATION: If same as patient check this box ☐ then skip to Emergency Contact

Name of INSURED: ____

____

Last First Middle I.

Address of Insured: ____

Street address City State Zip

Insured Date of Birth:______________ Patient Relationship to Insured______________________

mm/dd/yyyy Self, Spouse, Child, Other

Primary Insurance:_________________________Policy #__________________________

Group #__________________________ Effective Date: __________________________

Secondary Insurance:_______________________Policy #__________________________

Group #__________________________ Effective Date: __________________________

EMERGENCY CONTACT INFORMATION:

Contact Name:______________________________Number: ______________________

Relationship to Patient:____

PREFERRED PHARMACY:

Pharmacy:____Phone:________________________

PRIMARY CARE PHYSICIAN:

Name:____Phone:________________________

Address:____
Street City State Zip

REASON FOR EVALUATION TODAY: ____

I AM REFERRED BY: ____

I,_____________________________________authorize the medical treatment by a Community and Long-Term Care Psychiatry, L.L.C.

I have given to Community and Long-Term Care Psychiatry, L.L.C. consent to release protected health information (PHI).

I acknowledge full financial responsibility for services rendered by Community and Long-Term Care Psychiatry, L.L.C. I understand that payment is due at the time of service and agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I further understand and agree that in case I do not show up or call less than 24 hours before an appointment to cancel or reschedule, I will be charged a fee according to Community and Long-Term Care Psychiatry, LLC policies. I understand that this fee is not covered by my insurance and will be billed directly to me as it is my sole responsibility.

______________________ ____ ________________
Printed name of Patient Signature of Patient, Guardian or POA Representative Date

PATIENT HISTORY FORM

Date:_______/_________/________

NAME: ________________________ Birthdate: _____/______/_____

Last First M. I.

Age:___________Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?___________________________

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: specify)________________ ________________ ________________					Yes ☐ No ☐

AUTHORIZATION TO RELEASE INFORMATION

____
Person(s) and/or Organization

____
Address Phone Number

____
City, State, Zip Fax Number

Patient Name:____

Date Of Birth:____

Social Security#:____

I hereby authorize Community and Long-Term Psychiatry, LLC to receive medical records, reports, labs or X rays pertaining to me and to release and/or receive full information regarding my condition including etiology, diagnosis or prognosis.

I also authorize Community and Long-Term Psychiatry, LLC to receive any medical records, reports or any information pertaining to previous treatments of alcohol abuse and/or treatment of substance abuse, any psychiatric records or reports, and any information regarding treatment for AIDS or STD's. This authorization will remain valid for the course of treatment unless otherwise stated. A photographic copy of this authorization shall be valid as the original. It is understood that the person authorizing the release and/or to receive this specific information has the right to inspect and copy the information to be disclosed and that this information will not be re-disclosed without proper authorization.

____

Patient Signature/ Legal Guardian Signature Dat

COMMUNITY & LONG-TERM CARE PSYCHIATRY, L.L.C.
10004 Kennerly Rd. Ste 362B, St. Louis, MO 63128
Phone: (314) 525-5050 Fax: (314) 525-5072

Consent for Mental Health Evaluation and/or Treatment

Version for Children or Wards

Name:
Date of Birth:
Record #:

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child/ward will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or course of treatment and chronic care management, as may be applicable, by staff from Community and Long-Term Care Psychiatry, LLC (hereinafter "Provider"). I have received complete and accurate information concerning each of the following areas:
   a. The benefits of the proposed evaluation, treatment, and/or chronic care management (as applicable);
   b. Alternative treatment modes and services;
   c. The manner in which treatment will be administered;
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable); and
   e. Probable consequences of not receiving treatment.

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Missouri Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. A chronic care management will be conducted by a physician or a psychiatric nurse practitioner in collaboration with a psychiatrist.

2. **Potential Benefits of Evaluation/Treatment/Chronic Care Management:** Evaluation and treatment may be administered by way of psychological interviews, psychological assessment or with testing, psychotherapy, and/or medication management.. It may be beneficial to my child or ward, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child/ward's daily functioning so that appropriate recommendations and treatments may be offered. Chronic care management is expected to be beneficial to my child/ward, as they have two or more chronic conditions that are expected to last at least 12 months, and this type of intervention may prevent exacerbation or decompensation of these conditions, and/or my child/ward's overall functional decline. Possible benefits to treatment/chronic care management include child/ward's improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Medical Insurance and Financial Responsibility:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. Patient will be responsible for any charges not covered by insurance, including co-payments and deductibles. Patient hereby authorizes Provider or their designee to file a claim with child/ward's insurance company for the services rendered during the term of treatment and use the term "signature on file" as my signature. I authorize the medical insurance company to pay directly to Provider for the services rendered. I request payment of authorized Medicare benefits or Medigap benefits to be made on my behalf directly to the Provider, for any services that were furnished to my child/ward by the Provider or their designee. I authorize the holder of medical information about treatments and other services provided to my child/ward to release any information needed to determine these benefits to the health care financing administration, Medigap insurer, or their agents.

4. **Confidentiality, Harm, and Inquiry:** Information from my child/ward's evaluation and/or treatment is contained in a confidential medical record at Provider's offices, and I consent to the disclosure of same for use by Provider staff for the purpose of continuity of my child/ward's care. Information provided will be kept confidential with the following exceptions: 1) if my child/ward is deemed to present a danger to him/her self or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This authorization will be perpetual unless I give written instructions to revoke it, which I may do at any time.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child/ward. I also attest that I am the legal guardian and have the right to consent for the treatment of this child/ward. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Signature of legal guardian for minor/ward	Date	Signature of witness	Date

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10004 Kennerly Rd. Ste 362B, St. Louis, MO 63128
Phone: (314) 525-5050 Fax: (314) 525-5072

Consent for Mental Health Evaluation and/or Treatment

Version for Adults

Name:
Date of Birth:
Record #:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or course of treatment and chronic care management, as may be applicable, by staff from Community and Long-Term Care Psychiatry, LLC (hereinafter "Provider"). I have received complete and accurate information concerning each of the following areas:
   a. The benefits of the proposed evaluation, treatment, and/or chronic care management (as applicable);
   b. Alternative treatment modes and services;
   c. The manner in which treatment/chronic care management will be administered;
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable); and
   e. Probable consequences of not receiving treatment/chronic care management.

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Missouri Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. A chronic care management will be conducted by a physician or a psychiatric nurse practitioner in collaboration with a psychiatrist.

2. **Potential Benefits of Evaluation/Treatment/Chronic Care Management:** Evaluation and treatment may be administered by way of psychological interviews, psychological assessment or testing, psychotherapy, and/or medication management. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning so that appropriate recommendations and treatments may be offered. Uses of this evaluation or course of treatment may include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Chronic care management will be beneficial to me if I have two or more chronic conditions expected to last at least 12 months and this type of intervention may prevent exacerbation/decompensation of these conditions, or my overall functional decline. Possible benefits to treatment/chronic care management include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Medical Insurance and Financial Responsibility:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I hereby authorize Provider or their designee to file a claim with my insurance company for the services rendered during the term of treatment and use the term "signature on file" as my signature. I authorize the medical insurance company to pay directly to Provider for the services rendered. I request payment of authorized Medicare benefits or Medigap benefits to be made on my behalf directly to the Provider, for any services that were furnished to me by the Provider or their designee. I authorize the holder of medical information about treatments and other services provided to me to release any information needed to determine these benefits to the health care financing administration, Medigap insurer, or their agents.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Provider's offices, and I consent to the disclosure of same for use by Provider staff for the purpose of continuity of my care. Information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** This authorization will be perpetual unless I give written instructions to revoke it, which I may do at any time.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Signature of client	**Date**	**Signature of witness**	**Date**

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OFFICE POLICIES AND PROCEDURES

Thank you for choosing Community and Long-Term Care Psychiatry, L.L.C. as your provider for psychiatric services. We welcome you! We are committed to providing the finest personalized and professional care possible for our patients, and hope that the following information will help you answer some of your questions and help you understand how our office operates.

Please note: If you are experiencing a psychiatric emergency, call 911 or go to the nearest emergency room for urgent treatment.

OUR BUSINESS HOURS AND SCHEDULING APPOINTMENTS:

Patients are seen by appointment only; walk-ins will not be seen. Our office is open Monday through Friday from 8 a.m. to noon, and 1:00 to 5:00 p.m. for scheduling appointments. Prescription refills, appointment scheduling, and lab/test results should be handled during routine business hours. We will make every effort to schedule your appointment as soon as possible. Appointments may be scheduled by phone or in person at the office. At the time the initial appointment is made, a non-refundable fee of $30.00 is charged. This fee is considered a partially prepaid co-payment (or a partial payment in the case of a private pay patient) and is applied to the patient's account at the time the initial appointment is made.

__________Initials

Late arrivals for scheduled appointments: We understand that delays can happen, however we try to keep our patients and doctors on time. If a patient is 15 minutes late for their scheduled time, we may have to reschedule the appointment.

__________Initials

No call – no show fee policy: We realize that patients may need to change their appointments; however, we require a 24-hour notification of cancellation of your appointment so that we may offer that time to another patient. **If you fail to cancel your initial visit, you will not be scheduled for another one and the partially prepaid co-payment will not be refunded to you. If you fail to cancel your follow-up appointment, you may be billed for the scheduled time.** Our office charges $95 for a missed 15-20 minute follow-up visit, and $225 for missed 1-hour appointment. To avoid fees for broken appointments, you must show up on time or call at least 24 hours before your scheduled appointment to cancel or reschedule it. ***NOTE: These fees are a patient's responsibility, as insurance will not pay them.***

__________Initials

SCHEDULED APPOINTMENTS:

What to bring to your initial evaluation appointment: Your initial appointment will consist of a consultation to explain your diagnosis and treatment options. Please assist us by providing the following information at the time of your consultation, if applicable:

- A completed New Patient Forms Packet.
- A list of prior treating physicians, psychiatrists, psychologists and therapists.
- An information on any laboratory tests, procedures, or images completed in the past six months.
- If you have medical insurance, bring the cards issued by the insurance company.
- A government-issued picture ID.
- Your preferred form of payment. *For your convenience you can have your credit card information to be stored in your file.*
- You must bring in all prescription bottles before any refill of **current medications** prescribed by a previous provider will be issued. Under no circumstances will our office refill medications without records being received directly from your previous doctor's office.

What to bring to your follow-up appointment:

- A list of any treating physicians, psychologists, or therapists that you started to get treatment or were treated since your last visit at our office.
- An information on any laboratory tests, procedures, or images completed since your last visit at our office.
- Your current insurance card.
- Your current form of payment. *If you have your credit card information stored in your file, please make sure that its expiration date is current and updated in our system.*

Telemedicine Follow-up Appointment:

Before appointment:

- Please make sure before your appointment to download the doxy.me app or to register with **doxy.me** online.
- Make sure to **test the doxy.me** platform before your appointment. If you are unable to get the equipment to work, it is your responsibility to get a hold of the office the day before your appointment to make sure that your equipment is functional and works with the system. If you are unable to be contacted through the system, not in the virtual waiting room, or for any other reason unable to get your system to work prior to your appointment, it will be considered a late cancel / no show and you will be responsible for any applicable fees.
- Please make sure to send in you telemedicine follow up questionnaire and any screening tools applicable to your individual care and conditions 24 hours before your appointment. If this paperwork is not received, your appointment will need to be rescheduled and considered a late, cancel, or a no show, and you will be responsible for applicable fees.
- Please make sure to email any information on any laboratory tests, procedures, or images completed since your last visit.
- Please make sure the staff has your updated insurance card 24 hours before your appointment. *It may be wise to attach a copy of your insurance card to your follow up telemedicine paperwork.*
- Please make sure your medication list is current in your patient portal
- Please make sure the office has your current form of payment. *If you have your credit card information stored in your file, please make sure that its expiration date is current and updated in our system.*

SUPPLEMENTAL CONSENTS

This consent to treatment represents my consent to medical and psychiatric treatment provided to me or my child/ward by Community and Long-Term Care Psychiatry L.L.C (CLTCP), and all healthcare professionals working in collaboration with the practice. I voluntarily authorize the examinations, tests and procedures customarily performed on patients with my condition and consent to customary treatments as ordered by the providers, including medication treatment. I also consent to drug testing if deemed appropriate by my practitioner.

_________Initials

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made by any of CLTCP providers, employees, or affiliates, to the results of treatments or examinations.

_________Initials

I understand that medications may be prescribed by CLTCP provider for the treatment of my or my ward's condition. I recognize that I have the right at any time to ask more questions regarding the treatment. I also recognize that it is my responsibility to clarify any treatment decisions my provider has recommended. I also recognize that if I have further concerns, it is my responsibility as a patient or patient's representative to voice those concerns. I also agree that if I accept and take a medication, I am responsible for understanding risks vs. benefits of those medications and if I take a medication I am consenting to treatment and accept all risks of treatment as well as potential interactions with other treatments. If I accept off-label treatment, I acknowledge that I have the right to ask for alternative treatments that are not off-label and I understand that taking an off-label medication means I am consenting to all the risks associated with taking a medication not labeled or studied for my condition.

_________Initials

I understand that vitamins may be offered by CLTCP provider for the treatment of my or my ward's condition. I understand that supplements are frequently not regulated by the FDA. I understand that frequently supplements may interact with medications in a way that is not fully understood. I also recognize that it is my responsibility to clarify any treatment decisions the provider has recommended. I also recognize that if I have further concerns, it is my responsibility as a patient or patient's representative to voice those concerns. I also agree that if I agree for a treatment with a vitamin/supplement, I am responsible for understanding risks vs. benefits of those supplements and if I, or my ward, take a vitamin/supplement, I am consenting to treatment and accept all risks of treatment as well as potential interactions with other treatments. If I accept off-label treatment, I acknowledge that I have the right to ask for alternative treatments that are not off-label and I understand that taking an off-label vitamin/supplement means I am consenting to all the risks associated with taking a medication not labeled or studied for my condition.

_________Initials

I understand that treatment compliance is extremely important. I understand that by not making follow up appointments, not taking prescribed medications regularly, or not discussing with treating practitioner the personal decisions I make regarding the way I am taking my medications, could result in adverse effects

to my health up to and including death. I recognize it is my responsibility to notify the provider of any concerns or changes I believe are necessary for my (or my ward's) treatment plan. It is also my responsibility to make sure the provider knows what changes have been made by other treatment providers. I recognize that it is my responsibility to document my concerns or health changes and address them with my practitioner.

__________Initials

I have read or have had read to me this consent and understand and agree to its contents. I understand that the consent for medical treatment, authorization for release of information and assignment of financial responsibility will be valid for the duration of treatment and can only be revoked upon written notice. By initialing below I acknowledge that this consent form has been read in full and explained, as necessary.

__________Initials

MEDICATIONS MANAGEMENT:

Medication Refill Policy: You must notify us **during your visit** of any and all prescription refills needed before your next visit. Medications will be prescribed at the time of appointment, and you will always be given enough medication and refills until the next office visit, so refills are not necessary over the phone. This is to limit medication errors and to protect your safety. If you have missed or cancelled an appointment, you will need to schedule another visit and will be provided with enough medication until the re-scheduled visit, within 1-2 weeks of the missed appointment.

__________Initials

Refill of controlled substances: Prescriptions for controlled substances (stimulants or benzodiazepines) **will not be reissued** until 3 (three) calendar days before the date the prescription is due to run out. You are responsible for safeguarding your prescriptions and medications.

NOTE REGARDING OUR BENZODIAZEPINES PRESCRIBING STRATEGIES: We care about your overall safety, health and longevity. We expect all patients to be willing to gradually wean themselves off benzodiazepines over time and to acquire other healthier coping mechanisms.

__________Initials

PAYMENTS AND INSURANCE:

Payment policy: Payment in full of all applicable charges is due when the service is rendered. If you are unable to provide the payment of all applicable fees, your appointment will be rescheduled. For your convenience, our office accepts major credit cards, cash or personal checks. We do not accept post-dated checks. There is a $50 fee for checks returned for insufficient funds. Patients with balances over $150 must either pay the balance or make payment arrangements prior to future appointments being made.

__________Initials

Insurance: Our company is an "in network" provider for most major insurance carriers, and for Medicare. Before you come in for an appointment, please check with your insurance carrier regarding the amount of

co-payment that you will be charged for our service. As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. If the patient fails to provide us with the correct information, they are financially responsible for the office visit charges. **Please remember, any amount not covered by insurance is ultimately the patient's responsibility.** The required co-payment cannot be waived, as doing so may violate our contract with your insurance carrier. We accept "out of network" benefits from most out-of-state insurance plans. Our office no longer accepts Medicaid patients.

__________Initials

TELEPHONE POLICY:

We take pride in answering your call in person whenever possible. However, there are times when heavy call volume may prevent us from speaking with you directly.

If you get a recording, **it is important that you follow these instructions:**

- Please do not call more than once a day for the same issue.
- Please keep your message as brief as possible (name, number and reason for call). For example; "Jane Doe, 555-1212, I need to reschedule my appointment."
- Please allow up to 24 **business** hours for a return call, especially if you call late in the day.
- Medical issues will not be addressed over the phone. Please make an appointment.
- Office staff will be polite and respectful to you., and deserve the same in return.
- Calls may be recorded for quality control purposes.
- Abusive or incessant calls are cause for termination from our practice. All threats are reported to the proper authorities.

Call in Policy: To uphold the quality of care and in fairness to all of our practice patients, our providers cannot take time out of their scheduled appointments to accept or return patient phone calls. If you feel you must speak with your provider, please make an appointment to allow them to give you the care and attention you deserve.

FMLA/LEGAL/OTHER MEDICAL PAPERWORK HANDLING AND CHARGES:

Routine school or work excuses are available upon request at the end of your appointment. If time permits, brief forms (less than 5 minutes) may be completed during your allotted appointment time and there will be no additional charge. Longer forms and letters will be done outside of appointment time and the fee will be based on the time involved to complete this service. Please see below.

Simple (less than 5 minutes) No Charge

Moderate (5-15 minutes) $50.00

Lengthy (15-30 minutes) $100.00

Complex (over 30 minutes) $200.00/Hour

Upon written request, records will be copied. It typically takes a week to have copies made. Copies of charts will be mailed directly to the requesting entity. The fee for copying is:

$25.51 preparation/handling fee

$0.59 for each copied page

Payment of $50.00 for the copied documents must accompany the written request. Refund of overpayment will be placed into the patient's account. Any additional charge (for over than 20-page file) will be billed separately.

Mental health records are a standard practice in psychiatry. They are protected by both law and professional standards. While you are entitled to review a copy of your record, they can occasionally be misinterpreted given their professional nature. In rare instances when it may be deemed potentially damaging for our clinicians to provide you with the full records, we can ensure that they are made available to an appropriate mental health professional of your choosing. They will need to provide us with a written record request accompanied by the Release of Information form personally signed and dated by you or your guardian. Please note that professional fees will not be charged for any preparation time required to comply with such requests.

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TERMINATION POLICY:

It is the policy of this practice to establish and maintain a cooperative trust-based provider/patient relationship. Should the relationship, trust or mutual goals of the provider and patient not be realized, either party may terminate the relationship within the bounds of applicable state and federal laws, rules and regulations.

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PRIVACY POLICY:

Use of recording devices in the office is prohibited unless approved in advance in writing. Violators are subject to termination. The form, Notice of Privacy Practices (Long Form), presents the information federal law requires us to give our patients regarding our privacy practices. This notice is a pdf document which requires Adobe Reader software. It is most likely you already have this software on your computer; however, if you have difficulty click here to download and install Acrobat Reader for free.

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CONFIDENTIALITY:

Confidentiality is a cornerstone of mental health treatment, and is protected by the law. Aside from emergency situations, information regarding your care and treatment can only be released with your written permission. If you are seeking insurance reimbursement, insurance companies also often require information about diagnosis, treatment, and other important information as a condition of your insurance coverage. They may occasionally request some of your medical files as you have given them permission to access this information when you signed an insurance contract with them.

There are legal exceptions to confidentiality that may require us to disclosure the information about you:

(1) Danger to yourself – if there is an explicit threat to harm yourself, our staff is required to seek hospitalization for the patient, or to contact family members or others who can help us provide your

protection or aid in your hospitalization if necessary
(2) Danger to others – if there is threat by you of serious bodily harm to others, our staff is required to take protective actions, which may include notifying the potential victim, notifying the police, or any other appropriate authorities
(3) Grave disability – if, due to a mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, our staff may have to disclose information to your family members or the proper agencies in order to help you access to help meet those basic needs
(4) Suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person - even if it is about a party other than yourself - our staff must file a report with the appropriate state agency
5) Certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a subpoena.

Although these situations can be rare, our staff will make every effort to discuss the proceedings accordingly. We reserve the right to consult with other professionals or with our legal department when appropriate. In these circumstances, *your identity will not be revealed*, and only important clinical information will be discussed. Please note that such consultants *are also legally bound to keep this information confidential.*

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I have reviewed and understood the information above.

________________________	______________________________	___/___/___
Signature of Patient/Guardian	Printed Name	Date