San Antonio Family Psychiatry

Psychiatry for Adults, Adolescents and Children

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PSYCHIATRIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. The Psychiatrist-Patient Services Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. You may revoke this Agreement in writing at any time.

PSYCHIATRIC SERVICES: I usually conduct a one-hour initial evaluation. If treatment continues, I will offer follow-up appointments, which are usually for 30-50 minutes or 20- 30 minutes , depending on the type of treatment. Once an appointment is scheduled, you will be expected to pay for it, unless you provide at least one business day's advance notice of cancellation. For example, an appointment for Monday needs to be cancelled before close of business on the Friday before, in order to avoid a missed appointment charge. Insurance companies do not provide reimbursement for no-show appointments and/or appointments that you do not cancel with sufficient notice. A missed appointment fee will be charged for an appointment not cancelled with sufficient notice or for a no-show appointment. For example, if a 50 minute appointment is missed, you will be charged my fee for that type of appointment. As a courtesy, we try and confirm upcoming appointments by phone. Please provide us with phone numbers that you regularly answer during the business day. You are responsible for appointments that you schedule.

TELEPHONE CONSULTATION & FORMS COMPLETION FEES: I charge a fee for telephone calls relating to your care. Additionally, I charge a fee to complete forms, for medication prior authorizations and to write reports and letters. You will be invoiced for these charges and you are responsible for paying these charges.

CONTACTING ME: The office is usually open Monday through Friday, by appointment. We may close the office for holidays and vacations, and this will be stated on the telephone voicemail greeting. After hours and/or when the office is closed, you may leave a message on the voicemail for routine, non-urgent matters, and your call will be returned during normal business hours. For after hours emergencies/urgent situations, please call the office number, 210-492-1666 and you will be given the on-call physician telephone number on the telephone voicemail greeting.

LIMITS ON CONFIDENTIALITY: In most situations, I can only release information about your treatment to others if you sign a written authorization form. There are other situations that require only that you provide written, advance consent. I employ an office manager. In most cases, I need to share protected information with this individual for both clinical and administrative purposes, such as scheduling, billing and quality assurance. My office manager has been given training about protecting your privacy. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

PROFESSIONAL RECORDS: I maintain PHI about you in your clinical record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be confusing if read without the guidance of a mental health professional. I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $25.00 or more. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request. Insurance companies can request and receive a copy of your clinical record.

PATIENT RIGHTS: HIPAA provides you with rights with regard to your clinical record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records, and the right to request a paper copy of this Agreement.

MINORS & PARENTS: Patients under 18 years of age who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS: You are expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires other arrangements. If I am an in-network provider for your insurance, I will collect the portion of the fee that the insurance does not cover. Payment schedules for other professional services will be agreed to when they are requested. If your account is not paid in a timely manner and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency, hiring an attorney, or utilizing other options, which will require me to disclose otherwise confidential information. In most collection situations, the information released includes the patient's name, contact information, the nature of services provided and the amount due. If such legal action is necessary, these costs will be included in the claim.

PRESCRIPTION FEES: There is a **$25 fee per prescription** for prescriptions and refills that are requested at times other than during a scheduled appointment. There is no charge for prescriptions or refills accomplished at scheduled appointments. Please try to request prescriptions at least one week in advance.

INSURANCE REIMBURSEMENT: If you have health insurance for which I am a contracted provider, I can file insurance claims to help you receive your benefits. **Please note that *you*, not your insurance company, are responsible for full payment of my fees. If your insurance changes, you are responsible for notifying my office of this change *in writing*.** It is important that you find out exactly what mental health services your insurance policy covers. Your contract with your health insurance company requires that I provide the health insurance company information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes, I am required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. In some cases, the insurance companies may share clinical information with a national medical information databank. I can provide you with a copy of any report I submit, at your request. By signing this Agreement, you agree that I can provide requested information to your insurance carrier. **Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You may request a copy of this document.**

CONSENT FOR TREATEMENT: By signing this form, you consent to medical and therapeutic treatment provided by me based on your needs and my professional expertise as well as communication with me via email or phone as necessary. You have the right to refuse/decline treatment at any time.

Patient's Name (Please Print)_____Date:_____

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Patient's Signature (or Parent's or Guardian's Signature, for minors)