Patient Intake Form

My Psychiatrist, PLC

To be completed on first visit

Patient Information

First Name | Middle Name | Last name | Sex

Address Street | Apt/Suite | SSN:

City | State | Zip | Age | Date of Birth

Phone (Home) | Phone (Cell) | Phone (work) | Email address:

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐In Relationship ☐Engaged
☐Separated ☐Lives with Significant Other ☐Adolescent ☐Other

Billing Information

Responsible (skip if this info is same as above)

Address Street | Apt/Suite

City | State | Zip | Phone Number

Primary Insurance

Insurance Company Name | Effective Date | Exp Date

Policy Holder Name | Relationship | Policy Holder Date of Birth | Policy Holder SS #

Identification/Policy Number | Group Number | Policy Employer's Employer Name | Phone Number

Emergency Contact

Name | Relationship to Patient | Phone Number

Primary Care Physician

Primary Care Physician | Phone Number | Fax Number

Parent or Legal Guardian Information (For Children Only)

Full Name | Relationship | DOB

Street Address (if different than Patient) | State | City | Zip

Home Phone | Cell Phone | Work Phone

Patients name:_____

My Psychiatrist, PLC

12359 Sunrise Valley Drive, Suite 320, Reston, VA 20191

Consent and Cancellation Policy Agreement

Revised: 03/1/2014

(This agreement supersedes all previous related agreements.)

Consent for Treatment

I voluntarily give my permission to the health care providers of My Psychiatrist as they may deem necessary to provide Mental Health services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from My Psychiatrist's provider, or until I withdraw my consent in writing. I understand that the clinic doesn't provide 24 hours coverage for my medical/psychiatric need. In case of urgent or life threatening situation, I would either call 911 or go to nearest emergency.

_____

Patient, Parent or Legal Guardian Signature Date

_____

Patient Signature (For Adolescents) Date

Cancellation and Reschedule Policy

MY PSYCHIATRIST does not overbook appointments and specific time slot will be allocated for your appointment. Your clinician and other patients are directly affected if you fail to show up for your scheduled appointment. Every effort is made to see you on time and if you do not come or cancel in a timely manner, your clinician loses that income and cannot effectively fill that appointment time.

- All appointments must be canceled or rescheduled before 48 hours prior to the scheduled appointment.
- Failure to do so will result in a missed appointment charge. The charges are as follows:
  $80.00 for psychiatrists (M.D.), Nurse Practitioner, Physician assistant or psychologists (Psy. D.)
  $80.00 per scheduled unit of psychological testing, 3 units would be $240.00
  $70.00 for master level therapists
- I understand if I arrive 20 or more minutes late for an appointment, I will be charged for a missed appointment.
- I understand that if I arrive for an appointment without the proper co-pay, I will be assessed a $10.00 administrative fee to cover the additional administrative cost to the practice.
- I understand that it is my responsibility to check the appointment card at the time that it is issued to verify the proper date and time are listed on the card. MY PSYCHIATRIST, PLC will not waive a missed appointment fee because of an error on a card. **My Psychiatrist will send courtesy reminder email or phone call 1-2 days prior to appointment day. I understand it is my responsibility to remember my appointment.**
- I understand that in the event of snow or inclement weather I may cancel an appointment with less than the required notice if Fairfax County government (not the school) is closed and if I call to cancel my appointment PRIOR to the appointment time.

My signature here is my acknowledgement that I have read the MY PSYCHIATRIST, PLC cancellation policy and that I agree to adhere to the guidelines and fee schedule as set forth in this policy:

_____ _____

Patient or Guardian Signature Date

Patients name:_____

My Psychiatrist, PLC
Medication Consent and Refill Policy

This agreement supersedes all previous related agreements.
Revised: 03/1/2014

Medication Refill Policy:

Due to the necessity for communication on many levels, refilling medications through pharmacies can be a frustrating experience for both patients and staff. It is of the utmost concern to us that we refill your medications in a timely manner.

It is our policy to give enough medication and refill until next appointment. It is patient's responsibility to keep up with appointment to obtain enough medication on time. To minimize errors and for your safety, we discourage medication refill in between scheduled appointment.

In case if you must obtain medication refill before your next appointment, we suggest that you call your pharmacy at least three business days before you expect to run out of medications and ask the pharmacy to fax us medication refill request. Our clinician will refill medication enough only to cover until next appointment. We expect to have a standing appointment in near future before providing medication refill.

We do not, as a rule, prescribe stimulants, benzodiazepines and other control medications without evaluating patient in the office. We need police report if you ask medication refill request for control medication due to medication/prescription loss.

Our clinician may refuse to refill any medication if they believe it is clinically necessary to evaluate patient before prescribing medication.

Psychotropic Medications Policy:

I hereby consent to receive psychotropic medication as prescribed by my Psychiatrist/Nurse Practitioner. I have been informed of all of the side effects and adverse reactions to the medications. I understand that I may experience withdrawal symptoms if I stop taking prescribed medication abruptly. I understand that, on occasion, some psychotropic medications may be used for psychiatric conditions or symptoms, despite a lack of FDA approval for these uses. I accept this, and have had the opportunity to discuss my concerns and the possible risks, benefits; precautions and side effects associated with this/these medication(s).

I understand and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my physician.

If I have further questions or concerns after starting the medication(s), I understand that I should contact the prescribing physician as soon as possible.

By signing below, I acknowledged that I have read, understood and agreed with both Medication Refill and Psychotropic Medication Policy listed above.

_____

Patient, Parent or Legal Guardian Signature Date

_____

Patient Signature (For Adolescents) Date

Patient Name: _____

My Psychiatrist, PLC

12359 Sunrise Valley Drive, Suite 320, Reston, VA 20191

Financial Policy

Revised: 03/1/2014

(This agreement supersedes all previous related agreements.)

(Please read carefully before signing this document)

We are committed to meeting your healthcare needs. Our goal is to provide quality service while keeping your insurance or other financial arrangements as simple as possible. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. As medical care providers, our relationship is with you, not your insurance company.

Not all services we provide are covered by your insurance company. Some insurance companies arbitrarily select certain services they will not cover. While filing of the insurance claims is a courtesy that we extend to patients, **all charges are your responsibility** from the date the services are rendered.

In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. I accept financial responsibility for all clinical and administrative services provided by My Psychiatrist.

2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.

3. I authorize payment to My Psychiatrist, PLC for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

4. I understand that My Psychiatrist will file and attempt to collect from my insurance company. I further understand that if the claim is not paid within 60 days that I will be billed for the remaining balance. I agree to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met. You will be ultimately responsible to pay the balances.

5. You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

6. If your insurance coverage or your insurance carrier changes and you do not notify My Psychiatrists within 30 days of that change, you will be responsible to pay full amount for your service. My Psychiatrists reserves the right to NOT issue a refund. I agree to waive any insurance company policy rights that require refund of the aforementioned monies.

7. Payment for services, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

8. If your plan requires a referral from your primary care physician we will try to obtain one for you but **you are ultimately responsible for knowing if we have received a referral or not.** If we do not receive a referral from your primary care physician we will have to bill you for the visit.

9. We will try to obtain prior authorization for you but you are ultimately responsible for knowing if we have received such prior authorization or not. If your insurance company fails to pay us for our services due to failure to obtain prior authorization, we will have to bill for the visit.

10. Our office charges $35 for a returned check. My Psychiatrist has a "One Bad Check" Policy. If your account has one returned check then you will not be allowed to write checks for future services.

11. We will mail you a monthly statement for any outstanding balance. If your insurance carrier has not paid the claim within 30 days for the date of service, PLEASE contact your carrier and assist us in getting the claim paid.

12. We will try our best to assist you any way possible with your bills. Any balance that is over 90 days may be transferred to an outside collections agency for credit reporting. A patient that has been placed in collections must pay any prior balance owed to the practice and the COLLECTIONS AGENCY FEE and any attorney fees in cash.

13. Ancillary services, which are all services not part of an initial assessment (including exchange of information with other clinician) performed by the physician, psychologist, social worker, nurse practitioner, or therapist at My Psychiatrist that are provided during non-appointment times will be billed at the provider-specific hourly rate as noted below. Typically these services are not covered by insurance companies.

    Examples of such ancillary services include but are not limited to: All patient related phone calls including phone consultations with patient or family members, other clinicians, school officials (administrators, teachers, counselors, etc), attorney, etc., crisis counseling, time associated with preparing for non-appointment medication refills, completion of any forms during non-appointment times, etc. Legal and court related matters are billed at a higher rate and require a prior contract and retainer.

    Psychiatrists bill at a rate of $300.00 per hour. Legal services are billed at a rate of $350.00 per hour.

    Psychologists bill at a rate of $180.00 per hour. Legal services are billed at a rate of $350.00 per hour.

    Master's level providers (social workers, therapists) bill at a rate of $150.00 per. Legal services are billed at a rate of $250 per hour.

14. You allow our office and affiliated agencies to contact on any phone numbers (example: home, work, cell, etc.) or email address provided regarding medical and billing issues.

I acknowledge that I understand and accept this financial policy as a patient of My Psychiatrist.

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Signature	Date	Relationship to patient

Patients Name:_____

My Psychiatrist, PLC

12359 Sunrise Valley Drive, Suite 320, Reston, VA 20191

Notice of Privacy Practices

Revised: 03/1/2014

(This agreement supersedes all previous related agreements.)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at the Medical Practice in order to provide you with quality care and to comply with certain legal requirements.

2. Changes to this Notice
We may change the terms of our Notice, at any time. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

3. The following categories describe the different ways that the Medical Practice may use and disclose your medical information. Other uses and disclosures of your medical information that are not listed or described below will be made only with your written authorization. You may revoke this authorization, at any time, in writing, but it will not apply to any action we have already taken.

a. **For your treatment:** Your medical information may be used and disclosed by us for the purpose of providing medical treatment to you for another health care provider providing medical treatment to you
b. **To obtain payment for our services:** Your medical information may be used and disclosed by us to obtain payment for your health care bills or to assist another health care provider in obtaining payment for their health care bills.
c. **For our health care operations:** Your medical information may be used and disclosed by us to support our daily operations. These health care operation activities include, but are not limited to, quality assessment activities, employee review activities, training of health care professionals and students, licensing, and conducting or arranging for other business activities.
d. **For appointment reminders:** We may use or disclose your medical information to contact you to remind you of your appointment, by mail or by telephone. Our message will include the name of our practice or the name of our physician as well as the date and time for your appointment or a reminder that an appointment needs to be scheduled.
e. **To our business associates:** We will share tour medical information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information.
f. **As required by law:** We may use or disclose your medical information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
g. **As required by the Food and Drug Administration:** We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
h. **To your employer:** We may disclose your medical information concerning a work-related injury or illness to your employer if you are covered under your employer's policy in order to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related injury, in accordance with the law.
i. **For abuse or neglect:** We may disclose your medical information to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your medical information if we believe that you have been a victim of abuse, neglect or domestic violence as may be required or permitted by Virginia and/or federal law.
j. **For health oversight:** We may disclose your medical information to a health oversight agency for activities authorized by law.

k. **In legal proceedings:** We may disclose your medical information in the course of any judicial or administrative proceeding, in response to an order of a court of administrative tribunal (to the extent such disclosure is expressly authorized), and in certain cases in response to a subpoena or other lawful request.

l. **For law enforcement:** We may also disclose your medical information, so long as all legal requirements are met, for law enforcement purposes.

m. **Due to criminal activity:** Consistent with applicable federal and state laws, we may disclose your medical information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

n. **For worker's compensation:** Your medical information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally established programs.

o. **Regarding inmates**: We may use or disclose your medical information if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.

4. Your Rights

You have the right to inspect and copy your medical information. You may inspect and obtain a copy of your medical information that we maintain. The information may contain medical and billing records and any other records that we use for making decisions about you.

However, under federal law, you may not inspect or copy the following records:
psychotherapy notes; information compiled related to a civil, criminal, or administrative action; and medical information that is subject to law that prohibits access to medical information in certain circumstances.

We may deny your request to inspect your medical information. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your medical information. This means you may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or health care operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If we agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss any restriction you wish to request with your physician.

5. Complaints

You may complain to us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our CEO of your complaint. We will not retaliate against you for filing a complaint. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services.

6. Consent to Disclose: List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from My Psychiatrist as necessary during the course of your health care services:

Name and Relation Allowed Disclosure

Spouse: _____

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Signature _____ Date _____

Patient or legal guardian Name _____