Patient Name:_____ FORM DATE 1/2020

Patient Intake Forms
My Psychiatrist, PLC

First Name	Middle Name	Last name	Gender

Address Street	Apt/Unit #	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 Party (if minor or other than self)

Address Street	Apt/Unit

City	State	Zip	Phone Number

insurance Company Name	Effective Date	Exp Date

Primary 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

Patient Name:_____ FORM DATE 1/2020

My Psychiatrist, PLC

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

Treatment Consent and Cancellation/Medication Refill Policy Agreement

Consent for Treatment

I voluntarily give my permission to the health care providers (Psychiatrist, Psychologist, Therapist, Counselor, Physician Assistant or Nurse Practitioner) of My Psychiatrist, as they may deem necessary to provide Mental Health services such as evaluation, mental status examination, psychological testing, ordering laboratory test and medication management 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.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test or recommended treatment plan or medication ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

Cancellation Policy

MY PSYCHIATRIST does not overbook appointments and a specific time slot is allocated for your appointment. Your clinician and other patients are directly affected if you fail to show up for your scheduled appointment. Please note we will not refill prescriptions without a scheduled appointment.

- All appointments must be canceled before **48 hours prior** to the scheduled appointment. Cancellations for Monday appointments must be made by noon on Friday.
- Failure to give 48-hour notification so will result in a late cancellation/rescheduled appointment charge. The charge is $80 for all 15-minute and 30- minute appointments and $125 for all 45-minute and 60-minute appointments.
- Should you arrive late for an appointment, understand that your provider may not be able to see you and you will be assessed a late cancellation fee as noted above.
- It is your responsibility to correctly record your appointment time. My Psychiatrist will send a courtesy reminder email or text 2 days prior to appointment day. This reminder is a courtesy only. Again, you are responsible for noting the correct time of your appointment when you schedule it.
- In the event of snow or inclement weather, you may cancel an appointment with less than the required notice if Federal Government (not the local schools) is closed and if you call to cancel appointment PRIOR to the appointment time.

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.

If you must obtain medication refill before your next appointment you must allow at least 48 hours for our clinician to process the request. You must have an appointment scheduled and the provider will only write the prescription to cover time to the scheduled appointment. We suggest that you sign up for patient portal system and request your refill directly with your provider. Provider will provide medication via E-prescription. My Psychiatrist PLC will not call or fax prescription to your pharmacy unless our electronic prescription services is offline.

As a rule, we do not prescribe or refill stimulants, benzodiazepines and other control medications without evaluating a patient in the office. We require a police report if you ask medication refill request for control medication due to medication/prescription being lost or stolen. Our clinician may refuse to refill any medication if they believe it is clinically necessary to evaluate patient before prescribing medication.

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

_____	_____	_____
Signature	Date	Relationship to patient
_____	_____	_____
Name of Pharmacy	Location	Phone Number

Patient Name:_____ FORM DATE 1/2020

My Psychiatrist, PLC
Financial Policy Agreement

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 the filing of insurance claims is a courtesy that we extend to patients, **all charges are your responsibility** from the date the services are rendered.

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. It may become necessary for you to pay your account in full if your insurance company fails to pay for services. In situations if necessity to waive any insurance company policy rights that would prevent me from being responsible for these unpaid charges, I agree to waive and pay for the services rendered.

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.

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.

If your insurance company fails to pay us for our services due to failure to obtain prior authorization or referral, you will be ultimately responsible for the payment.

All in-person payment transactions are to be made by cash or credit card. Checks are only accepted when used to make payment by mail. My Psychiatrist has a "One Bad Check" Policy. If your account has one returned check, you will not be allowed to write checks for future services.

You will receive 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. 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. 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.

Ancillary services, which are all services not part of regular patient care, such as exchange of information with other clinician, non-appointment medication refills, completion of any forms during non-appointment times etc., performed by the clinical or administrative staff at My Psychiatrist will be billed at the provider-specific hourly rate as noted below. Typically, these services are not covered by insurance companies. 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 $170.00 per. Legal services are billed at a rate of $250 per hour.

By signing below, I accept financial responsibility for all clinical and administrative services provided by My Psychiatrist set forth in this agreement. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier. 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. I allow My Psychiatrist and affiliated agencies to contact on any phone numbers (example: home, work, cell, etc.) or email address provided regarding medical and billing issues.

_____	_____	_____
Signature	Date	Relationship to patient

Patient Name:_____ FORM DATE 1/2020

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.

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. 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.

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.
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

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.

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.

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.

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.

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.

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.

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.

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.

For health oversight: We may disclose your medical information to a health oversight agency for activities authorized by law.

I**n 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.

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

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.

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.
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.

5. 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.

6. 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 the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201

_____ _____ _____
Signature Date Relationship to patient

RELEASE INFORMATION

PSYCHIATRIC/ MEDICAL and/or ALCOHOL/DRUG ABUSE RECORDS

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Virginia law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information. This consent can be removed at any time with written request from the patient. If not previously revoked, this consent will terminate by the end of 2 years from today's sign date.

Patient Full Name: _____Date of Birth: _____

Release Information To:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Institution/ Clinicians:

Name: _____

Phone: (_____) _____Fax: (_____) _____

Information to be disclosed (please check one)□Complete medical Record/ Lab Results

□Verbal communication

□Other……

Records from (insert date) _____ to (insert date) _____

Reason for release of information:

□ Treatment/Continuing Medical Care □ Other *(Specify)*: _____

_____

Patient/ legal guardian signature _____

Date

_____

Patient/legal guardian name

My Psychiatrist health care provider authorizing to disclose this information (Office Use Only)

Clinician Name: _____ Date: _____

Clinician Signature: _____