Anxiety and OCD Treatment Center of Ann Arbor

Providing evidence-based treatment across the lifespan

PSYCHIATRY SERVICES TREATMENT AGREEMENT

Welcome to the Anxiety and OCD Treatment Center of Ann Arbor. This document contains important information about my professional services and business policies. It is important that you read this document carefully and discuss any questions you have with me. When you sign this document, it will represent your informed consent for evaluation and treatment and an agreement on policies.

PROFESSIONAL FEE SCHEDULE*

Type of Service	**MD/DO**
Initial Evaluation (90 min - 2 hours 90792)	$595.00
Complex Return Visit (40-50 min, 99215/98007)	$340.00
Routine Return Visit (20-30 min, 99214/98006)	$235.00

Other Fees

Phone consultation > 5 minutes**(per 5 minutes)	$30.00
Form preparation (per 5 minutes)	$30.00
No shows, late cancellations	
Weekday morning/afternoon	Session fee
Late Afternoon(4p+)/Evening/Weekend	Session fee + $50
Returned Check/Bank Fee	$25
Collection Agency Fee	$24

* Dr LaRosa and Dr. Hilton are nonpar with any insurance.

*We reserve the right to alter and update the Fee Schedule at any time. Review of the fee schedule occurs at minimum on an annual basis. All clients will be notified in writing of changes in fees at least 4 weeks prior to implementation.

EVALUATION

The initial session is an evaluation/consultation for medication/treatment recommendations. The evaluation will allow us to determine if our psychiatrist is the best fit for your needs or if you would be better suited seeing another provider. It is not a guarantee of ongoing treatment, medication prescriptions, or disability paperwork. Depending on the nature of your concerns, you may be required to be in dual treatment with a therapist before medication management can begin at our clinic.

BILLING AND PAYMENTS

Payment is due at the time of service. We require a credit/ debit/FSA card be on file for the payment of copays, deductibles, missed appointments, and other session fees. These fees will be processed post session by your provider/office staff. We ask that you allow at least 7 days for billing to complete. It is your responsibility to let your provider/office staff know of any changes to your payment method on file or update your payment method in your patient portal. Please let your provider know if you prefer to pay by cash or check, but note that a card will still be required to be on file in your account. It is your responsibility to check with your insurance to see if they provide out-of-network reimbursement for the evaluation and treatment sessions and to know what is covered by your HSA/FSA. Contact our office at any time if you think you may qualify for our Sliding Scale program and would like to apply.

You will be expected to pay for each session at the time it is held. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. Sessions may be paused after 3 missed session payments. If your account has not been paid for more than 90 days and you have not arranged payment, we have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, limited information is released including a client or guarantor's name, phone number, SSN, date of birth, demographic information, billing information, a copy of this agreement and the amount due. If such action is necessary, the cost of $24 incurred by our clinic will be included in the claim and charged to you.

Included in the cost of the session is the time the provider spends communicating with your pharmacy, refilling prescriptions, completing prior authorizations, coordinating care with your other providers and completing paperwork/letters on your behalf. If your provider must spend time outside of session equal to 15 minutes or more you will be charged the next session level, which is the complex return visit.

“FRIENDLY FRAUD” POLICY

“Friendly fraud” is a term defined as identifying a charge on your credit card as unauthorized by starting a chargeback request. This can result in excessive time spent on the part of our administrative staff in contesting these fraud claims, which can be extremely costly to businesses. We are fully aware that most patients are not realizing that asking for a refund for services rendered by stating an approved charge was unauthorized is technically a financial fraud. Please be aware that the first step to a chargeback process as defined by the Federal Fair Credit Billing Act (FCBA) is to contact the merchant and provide them with an opportunity to clarify any confusion. If you believe that your credit card has been charged erroneously, you must take the following steps before contacting your credit card company for a refund.

1) Login to your patient portal and review the financial summary/ledger under the Billing tab which will indicate what days charges were run and how each charge was applied for services.
2) Review the this initial treatment agreement form and billing practices that you signed in agreement, prior to participation in treatment with our clinic.
3) If you have any questions or concerns after reviewing the portal documentation, please send an email (phone calls are not sufficient due to the paper trial required under federal law) to frontdesk@anxietyannarbor.com stating you have a question or concern about billing.

If these steps are not followed prior to contacting your bank/credit card company about an unauthorized charge that is deemed as authorized by the card carrier and treatment forms provided at the start of treatment, you will be charged the fees we as merchants are charged for each false fraud claim of $30. Additionally if we are charged other fees by your bank/credit card company, you are also responsible for reimbursement for these fees. Please be aware under the FCBA, you are also subject to potential banking fees, credit consequences and loss of access to services. Any instance of false fraud claims without taking these 3 steps first, will subject you to loss of ongoing treatment at our clinic.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. You are expected to contact your insurance company prior to service to determine your behavioral health benefits coverage. If at any point it is determined that your benefit doesn’t pay for or pay fully for treatment, you are responsible for the charges.

Out of network services. Our office does not do out of network billing. An invoice will be available upon request to frontdesk@anxietyannarbor.com that you can submit to your insurance

company if you are seeking reimbursement. We cannot guarantee successful out-of-network reimbursement and strongly encourage you to contact your insurance company prior to services to determine your out-of network benefits. Please note that we are not able to assist with obtaining out-of-network reimbursement beyond providing an invoice of the service received. Any pursuit of reimbursement is between you and your insurance. Our office does not complete Single Case Agreements.

Flexible Spending. You will have access to proof of service receipts to submit to your flexible spending/health savings account for reimbursement. You can also contact the office to request a statement.

CANCELLATION POLICY

Because of the high demand for our services, initial evaluations require a 72 hour cancellation notice. New patient appointments not canceled with 72 hours advance notice will be charged the late cancellation fee. Established psychiatric patient appointments (follow up visits) must be canceled with 24 hours advance notice. If an appointment is canceled with less than 24 hours advance notice, you will be charged according to the current fee schedule. It is important to note that insurance companies and HSA/FSA cards do not provide reimbursement or coverage for canceled/missed sessions. _____

ARRIVAL/CHECK-IN POLICY

In order to provide a comprehensive assessment, new patients who check in 15+ minutes late must be rescheduled and the full appointment fee is charged. For follow-up appointments, patients are seen for the remaining appointment time. The exception is that patients who are 10+ minutes late for a 20-minute appointment cannot be seen, in which case the full appointment fee is charged. Patients who no-show twice may not be offered another appointment.

CONTACTING YOUR PSYCHIATRIC PROVIDER

Our psychiatric providers are generally not immediately available due to the nature of their work. For <u>routine</u> matters, please leave a message in the patient portal for your provider and she/he will make every effort to respond within 24 business hours (with the exception of weekends and holidays). If you have an <u>urgent</u> matter, please leave a phone message for your provider and he/she will respond within 24 business hours. If you cannot reach your psychiatric provider and feel that you have an <u>emergency</u>, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If your psychiatric provider will be unavailable for an extended period of time, you will be notified and provided with contact information for another psychiatric provider, if necessary.

OUTSIDE PROVIDER(S)

Individuals who are in treatment with an outside therapist/counselor and/or primary care provider are required to sign a Release of Information form to authorize communication and coordination of care between their psychiatric provider and their outside provider(s).

PRESCRIPTION REFILLS

Prescriptions are filled during appointments for enough medication to last until the next recommended visit. If you miss an appointment and need a refill before your next appointment and your psychiatric provider determines that a refill is medically necessary, an "interim medication refill" will be charged. Patients prescribed controlled substances must be evaluated at least monthly for the first several months, and then possibly every 3 months once stable. All patients are required to have a check in visit at least once a year in order to have the doctor continue prescribing medications. If a yearly check in is not preferred, you can ask your PCP to take over prescribing and our doctors will be happy to help facilitate. There are no early refills or new prescriptions for lost or stolen medication. Misrepresentation or misuse of controlled substances may be cause for discharge.

MEDICAID INSURANCE

Medicaid insurances require that prescriptions be written by a Medicaid participating provider. Our psychiatrists do not participate with Medicaid. If you have Medicaid insurance that you use for medication coverage, prescriptions written by our doctors will not be covered by your insurance. In such cases, our doctors can provide medication recommendations to your Primary Care doctor who can then write the prescription, if they choose to. Please discuss this with your Primary Care doctor prior to scheduling your evaluation or treatment at our office.

RELEASE OF INFORMATION & CONFIDENTIALITY

In general, the law protects the privacy of all communication between a client and a behavioral health provider. In most situations, we only release information about your evaluation or treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. Please be advised that if you provide an Authorization for your provider to collaborate with those on your care team, you may be responsible for meeting, phone call or extensive email fees to coordinate care. This is including but not limited to your current or past therapist, psychiatrist, primary care physician, teachers, or specialists. See our list of fees for rates.

Be advised, we must release information without consent in the following situations:

- If a client presents an imminent danger to him/herself, we may be required to seek hospitalization for the client, or contact family members or others who can help provide protection.

- If there is cause to suspect a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.

- If there is reason to believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.

- Parental involvement is essential to successful treatment and this may require that some private information be shared with parents. It is our policy only to share information that is considered necessary with a minor client's parents. This includes general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information, this will be discussed with the child, if possible, and an attempt will be made to handle any objections he/she may have.

- Children over the age of eighteen have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that treatment cannot be disclosed to anyone without the client's agreement.

- Where clinically indicated, the providers at the Anxiety and OCD Treatment Center of Ann Arbor will share relevant clinical information with one another, including protected health information.

It is important that any questions or concern that you may have now or in the future be discussed immediately with your clinician.

Health and Safety Policy

COVID19/Flu/Norovirus: The health and safety of our clients and staff are very important. While our clinic team will take every reasonable cleaning, sanitizing, and social distancing precaution, our Administrative Team will continue to monitor and follow any updates to CDC or state guidelines regarding Covid19, Influenza or Norovirus. In addition, we ask that all clients please follow these policies when attending sessions in-person at our office.

1. Wearing a surgical mask that covers your nose and mouth is optional. However, there may be instances where Anxiety and OCD Clinic staff may request that you wear a mask for the health and safety of yourself or other clients/staff. Masks are provided for free at the front desk.

2. Contact your provider if you are experiencing any potential Covid19, flu or norovirus symptoms, have tested positive for Covid19 or influenza, or have had direct contact with someone who has recently tested positive for Covid19, influenza or norovirus. It is possible that your session will be switched to virtual or cancelled in this case.
3. You may be requested to take a Covid19 test prior to any prolonged inperson sessions.

The Anxiety and OCD Treatment Center may change these policies based on current CDC guidelines, Covid19 case numbers in the community, or any other reason in order to protect the health and safety of all of our clients. You will be notified if any such changes occur.

The Anxiety and OCD Treatment Center of Ann Arbor and its staff are not responsible for unattended children or the theft/damage to personal belongings on clinic property. We kindly ask for the safety and confidentiality of your child, other patients and clinic staff that children remain under adult supervision at all times. Parents and guardians may be held responsible for any damages caused outside of scheduled treatment sessions by unsupervised children.

INTERRUPTION OR TERMINATION OF CARE

To ensure the continuity of care for all patients, it's important that account balances are kept up to date. If a balance becomes overdue by the equivalent of three or more sessions, services may be temporarily paused. We will always discuss these concerns with you before any treatment plans are changed. You will receive notifications through the patient portal as well as mailed statements outlining the balance and the length of time it has been outstanding. Accounts that remain unpaid for 90 days or more may be referred to collections, if there are no responses to our office. Services can resume immediately once payment has been made or a payment plan has been arranged with the office manager.

In some cases, a mental health practitioner may determine that it is in the client's best interest to end the therapeutic relationship—such as when progress is not being made, or when the concerns fall outside the scope of the provider's expertise. In these situations, we are committed to supporting you by offering referrals and recommendations for alternative care options. It is our greatest concern that we meet your personal treatment goal needs as well as honoring all of our professional ethics.

We reserve the right to terminate treatment for any the following reasons:

- Making a change to any prescribed medication without first consulting with provider here (including any non-psychotherapy treatment initiated from and outside mental health provider ie ketamine infusions, TMS, etc)

- If behavior is not respectful of clinician during appointments as outlined in the Center's *Patient Rights and Responsibilities*
- You seek treatment with an outside psychiatric provider without disclosing this to your provider here
- Omission or suspected dishonesty of substance misuse/abuse
- Inability to comply with recommended follow up appointments following any medication adjustment

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights concerning your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records 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 view and copy your records. Your clinician will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice. If you have a complaint, we encourage you to attempt to resolve it with your clinician. If the resolution is unsatisfactory to you, you may contact the Washtenaw County Recipient Rights Office at (734) 544-3000 and ask to speak with the Rights Officer of the Day.

MINOR CLIENTS

(please initial the appropriate option for your child. ***PLEASE READ ALL OF THE OPTIONS***)

_____ _____ lives with BOTH legal/biological parents/guardians and there is NOT a legal custody agreement in place,
(child's name)

_____ I am the Sole Legal Custodial Parent of _____ and there is **NOT** a custody agreement in place,
(child's name)

_____ I am the Sole Legal Parent/Guardian of _____ and there **IS** a custody agreement in place,
(child's name)

_____ I am the Joint Legal Parent/guardian of _____ and there **IS** a custody agreement in place,
(child's name)

_____ I am the Joint Legal Parent/guardian of _____ and there is **NOT** a custody agreement in place,
(child's name)

therefore I have the legal authority to enter this child into evaluation and treatment and to sign papers on the child's behalf. I understand that if there is joint legal custody with another person, that person will be asked to consent to treatment before treatment can proceed, may also be involved in the child's treatment and may receive communication from the provider. I will provide the Anxiety and OCD Treatment Center of Ann Arbor a copy of any legal custody agreements in place regarding the client.

By signing below I, _____, acknowledge that I
(Print) Client's Full Name or Parent/Guardian name if minor client
understand and accept all the terms in the above agreement for services provided by my clinician.

_____ _____
Client if 18 years or older)/Parent/Guardian Signature Date

I also acknowledge that I have received the HIPAA information (Notice of Privacy Practices) described above.

_____ _____
Client if 18 years or older)/Parent/Guardian Signature Date

I consent to following up no less than once annually with my psychiatrist, Dr. Hilton or Dr. LaRosa, for check ins regarding any prescription psychotropic medication they are managing.

_____ _____
Client if 18 years or older)/Parent/Guardian Signature Date

If I choose to terminate with Dr. Hilton or Dr. LaRosa as my prescriber of medication, I am obligated to give them/the clinic at least 30 days notice of treatment to terminate to allow for coordinated transfer of care to a different treatment provider (ie. primary care physician, different psychiatrist)

_____ _____

Client if 18 years or older)/Parent/Guardian Signature Date

Credit Card Consent

I, _____, consent to allow my provider(s) and the staff at Anxiety and OCD Treatment Center of Ann Arbor to store my credit/debit/FSA/HSA card information on file within their medical record system for myself and/or my child for the purpose of processing payments for services and/or fees incurred. I understand that such information will be stored in a secure manner, just as my (or my child's) medical record is stored securely.

I further attest to the following:

- ◊ I must keep a valid payment method on file and have completed the Authorization to Charge Credit Card in my patient portal.
- ◊ I will be charged after each session for the appropriate amount (e.g., copay, deductible, etc). My provider will notify me if the amount they regularly charge changes.
- ◊ If I miss or late cancel a session, I will be charged per the Cancellation Policy detailed in the agreement above.
- ◊ That an FSA or HSA card CANNOT be used for the purpose of a missed or late cancellation fee.
- ◊ I have read and understand the Friendly Fraud policy above.
- ◊ I may revoke this consent at any time by providing sufficient written notice. I understand that my consent is not considered fully revoked until my provider confirms receipt of said notice.
- ◊ If my card information changes or expires, I will update the method of payment on file in my account immediately by contacting the office or making the necessary changes in my patient portal.
- ◊ If the card on file is not the client's own card (i.e., in client's name), I consent to the Clinic contacting the card holder, if needed, to discuss billing matters should billing issues arise. The card holder can be contacted via phone at _____.

My signature below indicates that I have reviewed all information in this Consent to Evaluation. My signature also indicates that I have reviewed the Clinic's cancellation policy information and agree to the Credit Card Charge consent terms.

_____ _____

Client name Client or Parent/Guardian Signature

_____

Date