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.

Psychiatry Provider Name_____

PROFESSIONAL FEE SCHEDULE*

Type of Service	**MD (Board-Certified)**	**MD/NP/PA**
Initial Evaluation (60-75 min 90792)	$350.00	$250.00
Routine return visit (20-30 min, 99214)	$150.00	$110.00
Complex return visit (40-50 min, 99215)	$200.00	$160.00

Other Fees

Phone consultation > 5 minutes**	$25.00
Interim medication refill	$25.00
Form preparation (per 5 minutes)	$25.00
No shows, late cancellations	
Weekday morning/afternoon	Session fee
Late Afternoon(4p+)/Evening/Weekend	Session fee + $50

*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. **These are to be used sparingly when appropriate and are not used as a substitute for a face-to-face appointments.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. We currently accept checks, cash and most clinicians accept credit credits. Checks need to be made out to your individual provider. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. If your account has not been paid for more than 60 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, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. (If such action is necessary, the costs will be included in the claim.)

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. Our psychiatric providers may be individually paneled with different insurance companies. 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. Please note that none of our psychiatric providers are able to accept Medicaid or Blue Cross Complete insurance plans.

Out of network services. We can provide you an invoice that you can submit to your insurance company if you are seeking out-of-network 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.

Flexible Spending. We can provide proof of service receipts to submit to your flexible spending/health savings account for reimbursement.

CANCELLATION POLICY

Appointments must be cancelled with 24 hours advance notice. If an appointment is cancelled 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 do not provide reimbursement for cancelled 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 routine matters, please leave a message in the Valant 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). Our psychiatric providers will not respond to email messages. If you have an urgent 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 emergency, 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 at least every 3 months once stable. There are no early refills or new prescriptions for lost or stolen medication. Misrepresentation or misuse of controlled substances may be cause for discharge.

CONFIDENTIALITY

In general, the law protects the privacy of all communication between a client and a behavioral health provider. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. However, we must also 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.

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)

_____ The statement below does not pertain to (child's name) _____.

I am the:

_____ Sole Legal Custodial Parent

_____ Joint Legal Custodial Parent

_____ Legal Guardian

of (child's name) _____ and therefore I have the legal authority to enter this child into treatment and to sign papers on the child's behalf. I understand that if there is joint legal custody with another person, that person may also be involved in the child's treatment and/or may receive communication from the provider.

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

_____ _____

Client's Signature (required for clients 18 years or older) Date

_____ _____

Parent or Legal Guardian's Signature (required for minor clients 17 or younger) Date

_____ _____

Clinician Signature Date