B.T.M. Psychiatric NP Services, PLLC

Dear Client,

Welcome to *B.T.M. Psychiatric NP Services, PLLC* **and thank you for coming to your initial evaluation/intake appointment. Please take the time to review the attached information packet. It includes forms you need to fill out in order to provide accurate information about you or your child. It also describes the necessary information related to your consumer rights, your attendance, and the payment for services provided. I look forward to working with you and making sure your experience reflects the highest level of professionalism and the highest quality of care.**

Be Well,

Ms. B. Morrison, FPMHNP-BC
Board Certified Family Psychiatric Nurse Practitioner

6 Gramatan Ave, Suite 614**.,** Mt Vernon, NY 10550 **Phone:** (914) 214-1162 **Fax:** (914) 243-1970

B.T.M. Psychiatric NP Services, PLLC

PRIVACY NOTICE

At *B.T.M. Psychiatric NP Services PLLC,* **we comply with the laws and government regulations of HIPAA, NYS Mental Hygiene, and Social Service, regarding the use and disclosure of Protected Health Information (PHI). The confidentiality of your treatment and your clinical record shall be maintained in accordance. Your privacy will be protected to the fullest extent consistent with effective service delivery.**

RIGHTS OF CLIENT

As a client of *B.T.M. Psychiatric NP Services,PLLC*

You have the right to receive treatment in an environment which respects cultural diversity and ethnic heritage.

You have the right to receive treatment pursuant to an individually developed plan and to participate in establishment of any revisions of the plan.

You have the right to receive medically necessary care and treatment that is suited to your needs and is provided appropriately with full respect for your dignity and personal integrity.

You have the right to receive a full explanation of the service provided as part of the treatment plan.

You have the right to adequate notice of the use an disclosure of your protected health information (PHI).

You are allowed access to your medical record for collaborative care use ONLY. (Release of Confidential information form must be completed prior to releasing any information to another healthcare provider, service provider, or agency).

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PAYMENT POLICY FOR INSURED/UNINSURED CLIENTS

NON-MEDICAID & UNINSURED clients, are required to pay a ***FIRST-TIME CONSULTATION FEE***. (*See Fee Schedule for pricing).*

I am currently accepting the following **HMO or** *PPO* insurances:

1199
Aetna Health Inc.
Cigna
Empire HealthChoice HMO, Inc.
Empire Blue Cross Blue Shield HMO
Empire Blue Cross Blue Shield
Fidelis Care New York
United Healthcare (Oxford)

Your enrollment will be verified during the referral process and/or before the beginning of each session (evaluation, therapy and/or medication management). If you have a co-payment responsibility, **you will be required to sign a payment agreement and pay at the time of service.** Services will be delivered **if and only when eligibility and verification is confirmed**. If during your course of treatment your insurance plan changes (***cancelled or interrupted***) **you must notify the office and provided updated insurance card or information. If you do not inform the office you are responsible for payment of the visits, (see self-pay fee schedule).**

Your appointment time is reserved for you. I**f you need to cancel or reschedule an appointment, you must immediately respond NO to automative confirmation text received, CALL/TEXT 860-577-0605 and/or email** btmfamilypsych@gmail.com **at least 24 HOURS PRIOR** to your scheduled appointment time. Per contractual agreement, you will be charged a ***broken appointment fee of $75*** for any appointment which you have not given 24 hours notice of cancellation. This fee is due at the next scheduled appointment and if no appointment is rescheduled it will be billed to you. Non-payment of fees or more than two cancellations/no-show may result in discontinuation of treatment and/or legal action to collect debt.
In the event a collection agency or law firm must be retained in order to collect past due balances owed, you agree to pay any and all collection agency fees, court costs, attorney fees or incidental costs associated with collecting.

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FEE SCHEDULE

Below are the list of fees applicable to primarily self-paid clients. **FIRST-TIME (NON-MEDICAID)** clients are required to pay an **OUT-OF-POCKET CONSULTATION FEE.** Fees are subject to change and you will be notified well in advance of fee changes. ***All clients, must pay at the beginning of each session, PRIOR to receiving services.*** Payments can be made with cash or credit card. A sliding scale is offered as well and fees will be adjusted accordingly, depending on clients financial needs/limits You may be asked to present with updated W-2's.

Consultation (30-45 MINUTES)

-INSURED MANAGED MEDICAID (HMO) ……**FREE**
-INSURED (PPO)……..**$55.00**
-UNINSURED……**$55.00 (+ cost of Psychiatric Evaluation listed below).**

Psychiatric/Diagnostic Evaluation

- 45mins no med management ……..……**$175.00**
- 60mins w/medication management ……**$200.00**

Bariatric Clearance/Psychiatric Evaluation

-45mins (assessment) ……..……**$175.00**
-60min w/clearance letter, evaluation copy, and fax correspondence ……..……..**$200.00**

Psychopharmacological Therapy (*medication management)*

-15-20mins……..……**$50.00**
-30mins……..……**$75.00**

PsychoTherapy Weekly visits

- 30min sessions ……..……..**$100.00**
-45min session ……..……**$125.00**
-60min session ……..……**$175.00**

Family therapy including client & one + collateral

-45min ……..…**$175.00**
-60min ……..**$200.00**

Services with Interactive complexity: (*these fees are in addition to fees listed above****)***

-Spanish & English translation ……..……**$15.00/session**
-Administrative (Letters/completion of paperwork) ……..……**$15.00/session**
-Printing and faxing (MUST be paid in cash at time of visit)……..……**10cents/page**
-Extended sessions or sesión with therapy pet ……..……**$25.00/15minutes**
-Injectable Medications……..……**$25.00-50.00/injection**

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AFTER HOUR COVERAGE/ SAFETY AGREEMENT

In the event of ***CRISIS or URGENT*** *situations* that occur ***after*** office hours, please **CALL (914) 214-1162.** A voice messaging service is available and **calls will be answered or returned within 1-3 hours**. **For *EMERGENCIES* and** in the event that you do not get in contact with provider, **please DIAL 911 or go to the nearest hospital.** ***Please note that after hour phone service should not be used for routine matters such as cancelling or rescheduling appointments.***

QUESTIONS OR CONCERNS

Please use this page to write down any questions or concerns you may have and they will be addressed before or after the session.

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B.T.M. Psychiatric NP Services, PLLC

First Name:_____ MI_____ Last Name:_____

DOB_____ Age:_____ SS#_____-_____-_____ Gender (circle one) M/ F/ TG

Address:_____ City,State,Zip code_____

Home/Work Phone #: _____-_____-_____ Mobile #_____-_____-_____

Email: _____

EMERGENCY CONTACT

Name:_____ Relation _____ Phone: _____-_____-_____

Address:_____ City,State,Zip code_____

Home/Work Phone: _____-_____-_____ Mobile:_____-_____-_____

INSURANCE INFORMATION

Insurance:_____ ID#_____ Co-pay Amount:_____

Name on Card_____ *Relation _____

Name of Primary_____ *Relation_____

***S= self C= Child P=Parent H/W= Husband/or Wife**

PHARMACY

Name:_____ Phone: _____-_____-_____ FAX: _____-_____-_____

Address:_____ City,State,Zip code_____

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TREATMENT/ATTENDANCE & PAYMENT CONTRACT

I, _____, agree to attend sessions on a
Client or Guardian

weekly basis, monthly basis, or in accordance with the schedule/terms set forth with provider. I further agree to attend these sessions promptly/on time. I understand, if I am more than ***15min*** *late* ***without prior notification*** and ***communication with provider,*** the appointment will be rescheduled and a **$75 fee will apply** . I also understand that should I need to cancel my (or child's) appointment, I am expected to give **MORE THAN 24 hour notice** (***via voicemail, text and/or email***). If I do not, I (the client or guardian, **NOT THE INSURANCE**) will be charged in the amount of $75.00, due ***before or on*** the next scheduled visit. Self-paying clients must pay in full for missed session. Fees must be paid in order to schedule/confirm future appointments. Failure to do so will result in ***discontinuation of treatment with legal action to collect debt.*** If I **DO NOT** attend (cancel or no-show) ***TWO or MORE consecutive*** sessions, I (or child) will be considered **NONCOMPLIANT** and any appointments/services going forward will be:

-DENIED/DISCONTINUED *(Routinely set; weekly/biweekly appointment slots will be* ***stopped****. Future appointments will be scheduled* ***based on availability*** *and can be done so by client online at* ***www.btmfamilypsych.com*** *or by provider after each session.*

OR

-DOUBLE BOOKED. *You will be booked with another confirmed client and you may not been seen at the time scheduled and only when time permits.* ***In the event a collection agency or law firm must be retained in order to collect past due balances owed, you agree to pay any and all collection agency fees, court costs, attorney fees or incidental costs associated with collecting.***

X_____ _____
Signature of Client/Guardian Date

X_____ _____
Signature of Witness/Provider Date

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RREOCCURING/ELECTRONIC PAYMENT AUTHORIZATION FORM

You authorize charges to your checking/savings account or credit card for co-payments and or any other fees accrued while receiving services. You agree that no prior-notification is needed before charging. You should receive notice from us the day of or day prior to the payment being collected. A receipt for each payment will be emailed or texted to you and the charge will appear on your bank statement.

Please complete the information below:

I _____ authorize **B.T.M.**
(full name)
Psychiatric NP Services, PLLC, to charge my credit card indicated below on the day of or within 1-2 days after each scheduled appointment/session/visit for payment of my copayment/late cancellation/no-show fee/outstanding balance.

Billing Address _____Phone#_____

City, State, Zip _____Email_____

Credit Card (circle one)

Visa MasterCard Amex Discover

Cardholder Name _____

Account/ Card Number _____

Exp. Date _____ CVC_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **B.T.M. PSYCHIATRIC NP SERVICES, PLLC**, in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that B.T.M. PSYCHIATRIC NP SERVICES, PLLC may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

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B.T.M. Psychiatric NP Services, PLLC

PERMISSION TO PROVIDE SERVICES

I, _____, authorize *B.T.M. Psychiatric NP Services, PLLC* to provide mental and behavioral health services for:

Print Full Name of Person Receiving Services:_____

Date of Birth of Person Receiving Services:_____

I understand that in order to provide said services, *B.T.M. Psychiatric NP Services, PLLC* may need to conduct an assessment and provide treatment as necessary. Failure to comply with the treatment plan or recommendations, including but not limited to, attendance at sessions, routine oral toxicology, and or lab draws, can result in my termination from and discontinuation of treatment.

X_____ _____
Signature of Client Date

X_____ _____
Witness'/Provider Signature Date

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TELE-PSYCH SERVICE TERMS & AGREEMENT

Tele-psych services are face-to-face sessions set up with the provider virtually. ***Privacy and confidentiality are always maintained.***

Tele-psych services are available for clients **WHO**:

-**HAVE** had their initial assessment/psychiatric diagnostic evaluation performed in the office

AND/OR

-CAN NOT or **UNABLE** to come into make scheduled and confirmed appointments due to disability, special circumstances or excusable reasons: death in the family, crisis, prescheduled/ prior scheduled obligation etc…) however would like to still maintain treatment regimen.

-UNABLE to *cancel* appointment *24 hours prior to session*, however is available to and wishes to complete scheduled session. However, this **CAN NOT** be used **REGULARLY** for *missed appointments that have been* ***scheduled and confirmed.***

REGULARLY scheduled *tele-psych* services ***must be discussed, approved*** & ***confirmed FIRST.***

All fees (refer to fee schedule) for self paying clients and/or insured client's with insurance co-payments, can be paid in cash or **by credit card** (**+fee applies**).

ALL PAYMENTS MUST BE RECEIVED PRIOR TO INITIATING SESSION.

I have read, understand, and am in agreement with the terms written above, of ***tele-psych*** services.

X_____ _____
Client/guardian Print & Signature Date

X_____ _____
Witness/Provider Print & Signature Date

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TREATMENT WITH CONTROLLED SUBSTANCES POLICY& AGREEMENT

As a Family Mental and Behavioral Nurse Practitioner, I am required to administer care within my scope of practice. I am not mandated to treat disorders or psychiatric illness with FDA approved controlled substances. However, I will treat you with such medications, in the event that I deem it medically necessary and if the benefits out weigh the risks associated (abuse, addiction, and/or physical dependence). Any treatment with controlled substances will be done so at my discretion. Each client's controlled substance prescribing history will be check via the NYS I-STOP Prescription Monitoring Program.

I, _____ am aware, understand and agree that
(Name of Client)

-Just because I am are already receiving said medications from a previous or another provider, does not mean I will be continued on these medications here.

-Treatment with controlled substances will be used as an acute form of treatment. Initiation of this medication does not guarantee continuation and can be discontinued (with proper tapering) at any time if increased aforementioned risks are present.

-I may be required to have a random or routine urine toxicology performed and reports presented prior to initiating and during treatment with controlled substances.

-If I am prescribed controlled substances, **I must been seen by my provider every 15-30 days** (time frame set by provider) and treatment may or may not be continued.

-In the event this medication is discontinued by provider, I will be given a list of other prescribing providers. However, I am aware that I am not guaranteed to receive the same medications from my new provider.

X_____ _____
Signature of Client Date

X_____ _____
Witness'/Provider Signature Date

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ADULT SERVICES NOTIFICATION/DOCUMENTATION CHECKLIST

I have read, understand, agree to and or received the notifications of:

(Please initial)

_____ PRIVACY NOTICE & RIGHTS OF THE CLIENT

_____ PAYMENT POLICY FOR INSURED/UNINSURED CLIENTS

_____ AFTER HOUR COVERAGE/ SAFETY AGREEMENT

_____ FEE SCHEDULE

_____ PERMISSION TO PROVIDE SERVICES

_____ TREATMENT/ATTENDANCE & PAYMENT CONTRACT

_____ REOCCURRING PAYMENT/EFT AGREEMENT FORM

_____- TELE-PSYCH SERVICE TERM & AGREEMENT

_____ TREATMENT WITH CONTROLLED SUBSTANCES POLICY& AGREEMENT

_____ AUTHORIZATION TO RELEASE HEALTH INFORMATION

_____

Printed name of Client & Date of Birth

X_____ _____

Signature of client/guardian/parent **Date**

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