Welcome to Psychiatry & More

Thank you for choosing us to care for you and your family. The purpose of this letter is to explain expectations during your first session. We also want to provide information about policies, procedures and other issues that may arise during treatment.

The first visit usually lasts 45-60 minutes. The focus of the first session is to determine your needs, clarify your specific problem, and outline a treatment plan. At the end of this visit, you will be given specific recommendations to start your treatment plan.

Your appointment time is reserved exclusively for you. If you are going to be late, please contact our office. Please call **48 hours** prior to your appointment to confirm your attendance. If you will be more confortable with a friend or relative, feel free to invite them.

Prior to your appointment, complete the enclosed **Intake Assessment Form**. This will save time, provide valuable information and allow more time for discussion during your first session. After completion of form, bring copy with you to your appointment.

Insurance. Although our office will verify your benefits, in order to ensure our services are covered by your insurance, we suggest you contact them prior to first appointment. We recommend asking the following questions:

1. Are mental health services covered?
2. Is there a mental health deductible in addition to medical deducible?
3. Is there a co-payment or percentage you are responsible for?
4. Are our providers signed up with your insurance?

As a service, our office will file your insurance claim. Co-payments and unmet deductibles will be due at time of service. If you are unaware of your benefits and we are not able to obtain that information for your insurance, you will be responsible for entire fee at time of service. You will be reimbursed for any amount we collect from your insurance.

A 24 hour notice is required for all cancellations or you will be billed a fee. If your insurance requires treatment plans to be completed, this will be done at follow up appointments. It is your responsibility to keep track of appointments, authorized visits and treatment plans.

We hope this was helpful information and look forward to seeing you. If you have further questions please contact our office at 405-768-4904

Policies and Procedures

Office Hours

Office hours are Monday through Friday 8:00 am to 5:00pm, except holidays. We are closed for lunch 12:00-1:00pm. If you have an urgent problem after hours, please contact provider on call. To reach the on call provider, call the office number 405-768-4904 and will be prompted to that extension.

Telephone Calls

Our phones will be answered from 9:00am -12:00pm and 1:00pm -5:00 pm. You may leave a message on our answering machine after hours and your call will be answered on the next business day. Calls received on weekend and holidays will be returned on the next business day. After-hour consultations with a provider are reserved for emergencies. Providers will answer phone messages at the end of the business day, after all patients are seen. Any voicemails left after 3:30 will be answered the next business day.

Prescriptions and Refills

Allow 3 days to process prescription renewals and/or pick up requests. You are responsible for knowing when your medication will run out and accounting for the time it takes for our providers to authorize your request. Have your pharmacy fax a request to (405) 768-4934.Prescriptions require a scheduled follow up appointment before we will refill. Please ensure you have enough to last until next appointment. No refills will be authorized if there is a history of missed appointments.

Controlled prescriptions cannot be filled by a request from your pharmacy so please call the office to request a refill. No controlled prescriptions will be replaced if lost, stolen, misplaced or overused. No Prescriptions will be refilled on weekends and holidays. Prescriptions phone in hours are Monday-Friday 9:00am to 5:00 pm. Prescriptions will not be filled for unauthorized walk-in patients. New symptoms require an appointment. Providers will not diagnosis over the phone. Medications are for prescribed individual's use only. It is illegal to share or sell medication. According to DEA regulations, patients taking controlled substances, must be seen every 3 months minimally and at provider's discretion.

A "Signed "Control-Substance Policy" is required for narcotic/controlled substance medications. Our office takes the controlled substance policy very seriously. When provider-patient relationship is strained related to drug seeking behavior, providers may continue services but cease prescribing controlled substances. In other instances, providers may choose to terminate care and give direction to seek care in another office. Termination is at provider's discretion. Termination reasons include but not limited too noncompliance, drug seeking behavior, abusive behavior toward staff, providers, patients and visitors.

Controlled Substance Policy

Due to recent guidelines by standard health maintenance agencies, we reserve the right to conduct an initial urine drug test and every 60 days thereafter for patient prescribed a controlled substance for sleep, anxiety or any other condition.

I have read and agree to all policies and procedures listed above.

Signature _____ Date _____

Patient Information

Please complete information in provided spaces. This and all information shared with Psychiatry & More is regarded at strictly confidential and will not be shared without your written/signed consent.

Patient Name _____ Referred by _____

Address _____City _____ State _____ Zip_____

Sex _____ DOB _____ Marital Status _____ Gender Identity_____

Email _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____ SSN _____

Primary Insured/Responsible Party

Name _____ Address _____

City _____ State _____ Zip _____ Phone_____

SSN _____ DOB _____

Insurance Information

#1 Company _____Policy # _____

Policy Holders Name _____ DOB _____ SSN _____

Mail Claims to _____ Phone _____

#2 Company _____Policy # _____

Policy Holders Name _____ DOB _____ SSN _____

Mail Claims to _____ Phone _____

Authorizations and Agreements

Payment policy and Cancellation agreement: I understand that the office files my primary insurance as a courtesy, but the bill is MY responsibility. I am aware that a cancellation notice must be given **24 hours** in advance to avoid a charge.

Release of information and Assignment of Benefits agreement: I authorize Psychiatry & More to release any information acquired in the course of my treatment to my insurance company and assign the payment due to me to Psychiatry & More.

Signature _____ Date _____

Patient Record of Disclosure

HIPPA Privacy Rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is permitted to request confidential communication on PHI be made by alternative means, such as sending correspondence to your office instead of home.

I Wish to be contacted in the follow way: (Check all that apply)

☐ Home Telephone: _____
____ Ok to leave message with detailed information
____ Ok to leave message with call back number only

☐ Cell Phone: _____
___ Ok to leave message with detailed information
___ Ok to leave message with call back number only

___ Ok to receive email appointment reminders
___ Ok to receive SMS text message appointment reminders
___ Ok to receive voice appointment reminders and messages

Patient Signature _____ Date _____

Printed Name _____ DOB _____

Parent/Guardian _____ Date _____

Printed Name _____ Relationship _____

The Privacy Rule requires healthcare providers to take reasonable steps to limit use or disclosure of and requests for PHI to the minimum necessary to accomplish intended purpose. The provision do not apply to the uses or disclosures made pursuant to an authorized request by individual.

NOTE: Uses and disclosures may be permitted without prior consent in an emergency

Acknowledgment of Notice of Privacy Practices:
A description of how medical my medical information will be uses and disclosed by Psychiatry & More is in "Notice of Privacy Practice." A copy is posted at clinic site and available if you would like a copy.

I have accepted a copy of "Notice of Privacy Practice" ____ yes ___ no

Reason for refusal, if no _____

Informed Consent, Confidentiality, Description of Services

Description of services: It is my understanding that the some providers in this office are Advanced Nurse Practitioners qualified and licensed in the State of Oklahoma to provided medical treatment and psychotherapy. Psychotherapy involve discussing in detail my background, concerns, areas that may cause emotional pain for the purpose of attempting to develop new coping skills to deal with concerns in my or my child's life. I understand I am free to withdraw from a therapeutic relationship at any time and only responsible to pay for completed sessions.

Confidentiality: All services provided and all information obtained is kept confidential and cannot be released with written consent. However, there are special circumstances under which confidential information could be released, such as:

1. A "duty to warn" ethic allows provider to break confidentiality when danger exists to the patient or others
2. Under certain circumstances, the court may subpoena patient records and may order testimony of provider during court hearing
3. Third party payers, such as insurance, have the right to review records prior to payment
4. Delinquent accounts may be turned to Collection Agency
5. Based on clinical judgment, consultation with another professional with respect to treatment maybe sought
6. Actual or suspected abuse to children or elderly must be reported to authorities. Medical providers are mandatory reporters.

Your signature indicated that you have read and understand the above information and consent is given to provide services to you and/or your child (children) _____ who is(are) not of legal age.

Signature _____Relationship to Patient _____Date _____

Witness _____ Date _____

Advanced Beneficiary Notice

Patient Name _____

Medicare/Private Insurance will not pay for all your health care costs. They only pay for covered items and services when Medicare/Private Insurance rules are met. Some items or serves they do not cover are described below. The fact that Medicare/Private Insurance will not pay for a particular item or service does not mean you should not receive it.

Medicare/Private Insurance does not pay for these services:

- Prior Authorizations
- Letter/Forms completed
- Patient Assistance for Medications
- Phone Sessions

I understand I will be responsible for payments of these services

_____ _____

Signature of patient or legal guardian Date

Financial Policy and Missed Appointment Policy

Self-Pay Fees: Vary depending upon service

Medication Management: Initial Evaluation $275 Medication follow-up: $150 for 45 min
$95 for 30 min

Psychotherapy: $100 for 50 min $70 for 15 min

Insurance Patients: If you have insurance, our office is happy to call and verify benefits and file a claim with your insurance. If insurance covers a portion of your therapy, we will wait 90 days for them to pay. However, you will be responsible for your deductible and co-pays at time of service. You will be responsible for services not covered by insurance and balance not paid within 90 days will be charged to card on file.

Self-Pay Patients: Patients without insurance or with high deductible are responsible for cost of their care. Payment is expected at time of services rendered.

Methods of Payment: We accept cash, checks and all major credit cards. If you choose to pay by credit card there will be a convenience fee $3 for all transactions. If paying by check: $20 fee for return or bounced check

Missed Appointment Policy: A full 24 hours is required for cancellation of an appointment. A $50 cancellation fee will be charged to card on file if this requirement is not met. Inclement weather cancellations do not apply.

Legal Proceedings: If you become involved in legal proceedings that require your provider's participation you will be required to pay for all time, travel and preparation. Fee: $300 per hour with a 3-hour minimum for any legal participation.

I have read and agree to the above conditions.

_____ _____
Signature Date

Credit Card guarantee for Personal Balance

The credit card guarantee ensures your accounts stays up to date. Your card will be kept on file and only used when payments are not received by mail or in person. You can pay co-pays, special services or bills with your credit card on file, if you choose. No show and/or cancellations made without 24 hour notice will be charged to credit card.

CREDIT CARD: Visa MasterCard Discover AMEX CARD # _____

Card holder's Name_____

Card Holders Billing Address _____

Exp Date _____ 3 digit CID _____

I agree to above terms and authorize you to charge any payments not paid by the date due.

_____ _____
Signature Date

Release of Information

I. INDIVIDUAL INFORMATION (Patient Information)

Name _____DOB _____

Address _____ Phone_____

II. SCOPE AND PURPOSE FOR SHARING INFORMATION: I understand protected health information is information that identifies me. The purpose of this authorization is to allow Psychiatry & More to share my protected health information.

II. AUTHORIZATION & INFORMATION TO BE SHARED: I authorize Psychiatry & More, as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations Authorized to receive my information:

_____

Name/Phone/Relationship

_____

Name/Phone/ Relationship

_____

Name/Phone/Relationship

B. Information to be shared:

__ Medical ___ Scheduling/Appointments ___ Refills ____ Financial/Billing information

__ Labs __ All __ Other _____

IV. EXPIRATION AND REVOCATION

A. This authorization will expire 1 year after date singed

B. Right to Revoke: I understand I may change this authorization at any time. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
2. I understand if the person/organization authorized to receive my protected health information is not a health plan or provider, privacy regulations may no longer protect the information
3. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.
4. Acknowledgement of Notice of Privacy Practices: A description of how my information will be used and disclosed is in " Notice of Privacy Practices," which I should read prior to signing this agreement. A copy is on site and has been offered.

Signature _____ Date _____
(Patient or Legal Representative)

Printed Patient or Legal Representative Name _____

Telemedicine Services

Introduction

Telemedicine involves the use of electronic communication to enable health care providers to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow up, and education, and may include any of the following:

- Patient medical records
- Images
- Live two way audio and video
- Output data from medical devices and sound/video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

Benefits

- Improved access to medical care by enabling patient to remain in his/her location
- More efficient medical evaluation and management
- Obtaining expertise of a provider in areas that are underserved.

Risks

- In rare cases, information transmitted may not be sufficient to allow appropriate medical decision making by the provider
- Delays in medical evaluation and treatment could occur due to difficulties or failures with equipment
- In rare instances, security protocols could fail causing a breach of privacy of personal medical information.

Tips

- Check internet connection
- Ensure equipment is working
- Find a quiet, private location
- Write down questions
- Dress appropriately

Scheduling your Appointment

- A staff member will contact with available date/time
- An email with information and directions will be sent prior to appointment

Logging into Telemedicine Visit

- Follow link provided instructions or on website.

Informed Consent for Telemedicine Services

Patient Name _____ DOB _____

1. **Purpose**: The purpose of this form is to obtain consent to participate in telemedicine consultation
2. **Medical information and Records**: All existing laws apply to this visit
3. **Confidentiality**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks with this visit and all existing confidentiality protections under federal and state law apply to information disclosed in this visit.
4. **Rights**: You may withhold or withdraw consent to telemedicine visit at any time without affecting future care.
5. **Disputes:** You agree that any dispute arriving from this visit will be resolved in Oklahoma and Oklahoma law shall apply to all disputes.
6. It is important to use a secure internet connection rather than a public.
7. It is important to be on time
8. If you are not 18, we need permission of parent or legal guardian
9. **Payment of Services**: You agree that Psychiatry & More LLC reserves the right to bill a telemedicine visit to your insurance company. You are responsible for any patient portion of the visit prior to visit completion. You should confirm that your insurance covers telemedicine visits and if not you are responsible for full payment.
10. **Risks, Consequences and Benefits**: You have been advised of all potential risks, benefits, and consequences of telemedicine. You have had the opportunity to ask questions about information in this form and about the visit. All questions have been answered and you understand the written information provided.

I agree to participate in telemedicine appointments

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship to Patient

Intake Assessment Form

Name _____ Age _____ DOB _____ Date _____

Place of Birth _____Religion _____ Gender Identity _____

With Whom do you live _____

Occupation_____ Highest Education level completed _____

Degree (If any)_____

Martial History

Current Marital Status_____

If you have been married, how many times? _____If you have been divorced, how many times? _____

Emergency Contact

Name _____ Relationship _____

Home phone _____ Work Phone _____ Cell Phone _____

Medical

Primary Care Provider_____ Phone _____

Counselor/Therapist _____

Females of childbearing age: Are you pregnant or plan to become pregnant? Yes No

Other medical providers _____

_____

Allergies _____

Past Medical problems (high blood pressure, DM) _____

_____

Past Surgeries _____

_____

Reason for this visit

Describe your illness from first time present

Describe expectations regarding treatment

Past Psychiatric diagnosis

Family History of Medical or Psychiatric diseases

Current Medications (Prescribed and supplements)

Medication	Dose

Review of Systems (Circle all that apply)

Weight Loss Fatigue Fever Eye Pain Double Vision Glasses/Contacts Sore Throat

Difficulty Hearing Sinus Trouble Dizziness Fainting Swelling in ankles Chest Pain

Depression Loss of Hair Heat/Cold intolerance Cough Shortness of Breath

Nausea/Vomiting Anxiety Diarrhea Constipation Reflux Abdominal pain

Urinary complaints Hives Eczema Easily Bruise Joint Pain Rash Headaches

Numbness/tingling Mood Swings

Suicide and/or Hospitalizations

Have you ever had thoughts of suicide? Yes No

If yes, when was last time _____

Have you ever attempted suicide? Yes No

Do you have thoughts of suicide now? Yes No

Have you ever been hospitalized for psychiatric issues? Yes No

If yes, When _____ What circumstance _____

Substance Use

Do you or have you ever smoked tobacco? Yes No

Pack/per day? _____

Quit Date _____

Do you drink Alcohol? Yes No

Average drink per week _____ per month _____

In the past 12 months have you had 3 or more drinks in a 3 hour period on 3 or more occasions? Yes No

Was there ever a time you felt like you were drinking too much? Yes No

Circle any Drugs you have Taken

Marijuana Amphetamine Heroin Opiates PCP LSD Cocaine/Crack Sedatives Benzos

Other _____

Are you currently using illegal drugs? Yes No Use per day _____ per week _____

Do you have a medical Marijuana card? Yes No Use per day _____ per week _____

Circle if during childhood you:

Afraid to go to school	Had Tics
Had difficulty ready, writing or math	Had stutter
Was truant	Nightmares
Failed or repeated a grade	Ran away from Home
Wet bed after age 5	Cruel to Animals
Frequently Lied	Set Fires
Moved Frequently	Worried excessively

Check if you have had:

____ Head Injury ___CAT scan/MRI of Brain ____ Seizures ___ EEG

____ Neurological Exam

Controlled Substance Agreement

Controlled substance medicationsare very useful but have a high potiential for tolerance, depedance, and misuse. Therefore, these medication are closely monitored by local, state and federal governments. Some can cause withdrawl when trying to discontinue. It is important to talk to our provider when wanting to discontinue for safety purposes. As a patient of Psychiatry & More, I agree ot the following(**please initial**):

1. ___ I am responsible for the controlled medications prescribed to me. I will keep them in a safe place. If my prescriptions are misplaced, stolen, or if "I run out early," I understand this medication will not be replaced regardless of situation

2. ___ Refills of controlled medications will be made only during office hours. Refills will not be made on the same day as requested, nights, holidays or weekends.

3. ___ I will not increase my medication dose on my own

4. ___ I will not get controlled medications from any other doctor or clinic. If I am prescribed another controlled medication, I will let my provider know what I am taking and will call Psychiatry & More to discuss the new medication before taking it.

5. ___ I understand that my provider may ask for routine or random urine drug screen if he/she feels that it is necessary. I understand that my insurance may not pay for this test and I will be responsible for the cost.

6. ___ I understand that there is risk of addiction, physical dependence, and withdrawal from controlled substances. I will not discontinue without talking to my provider so a safe taper can be discussed.

7. ___ I understanding mixing controlled medication with things such as pain medicine, muscle relaxants, and alcohol. Illicit drugs, or other substances that relax central nervous system can be dangerous to my health and could result in death.

8. ___ I understand the office monitors my access to controlled substances through the Oklahoma's Bureau of Narcotics and Dangerous Drugs Prescription Monitoring Program

9. ___ I understand if I violate this controlled substance contract due to non-compliance, the medication will be discontinued or a safe taper will be prescribed. Termination of services could occur.

I have been fully informed regarding addiction of controlled substance medications. I know some individuals can develop a tolerance requiring a dose increase to achieve desired effect. An increase can result in dependence of medication. If I need to stop this medication, I must do so under medical supervision. By signing below I understand and accept the above agreement

Signature of patient/Legal guardian _____

Date _____