Sher Psychiatry Office Policy

Patient Name_____ Date_____

Duration of Sessions
Sessions are typically scheduled for 53 minutes for therapy and 15-23 minutes for medication management. The extra seven minutes are allotted time for documentation. Sessions are expected to start and end at the scheduled time.

I.N._____

Cancellations/Missed Appointments
Because the appointment time is reserved for you, it is necessary to ask you to give a 24-hour advance notice if you are unable to keep your appointment. If a 24-hour notice is not provided, your appointment will result in a late cancellation and a **$80.00 fee** will be applied to your account. If you fail to attend your appointment, this will result in a no-show and a **$80.00 fee** will be applied to your account. It is your responsibility to pay **the $80.00 fee**. Further, if you miss or cancel or reschedule late regularly, your account will be flagged and reviewed by the clinical team**. Three or more late cancellations and/or no-shows will result in dismissal, and you will be provided with a referral list.**

I.N._____

Re-evaluation Process
I understand if I am not seen by a provider for a period of 6 months or longer, I will be considered a new patient and must schedule an intake evaluation.

I.N._____

Emergencies
Due to varying office hours for each provider, we cannot guarantee you will be able to reach your therapist or medical prescriber immediately in the case of psychological emergency or crisis. If you are experiencing an emergency, we strongly recommend you call 911 or proceed to your nearest emergency room.

I.N._____

Fees and Charges
The fees and payments for initial evaluation, psychological testing, therapy sessions, and medication management sessions are due upon services rendered. Fees and costs may vary depending on service provided and individual insurance coverage. We accept all major credit cards, personal checks, and cash payments. All returned checks or insufficient funds are subjected to a $30.00 charge per occurrence. All balances that are delinquent for longer than 90 days are subjected to collections.

I.N._____

Billing
Your individual health care insurance will be billed for each service provided. You are responsible for any and all copays, coinsurances, deductible amounts, and non-covered services. You are responsible for keeping your account current as well as providing us with accurate up-to-date insurance information. Since insurance plans vary and are constantly changing, it is your responsibility to be aware of your mental health benefits. If you have questions regarding your coverage, we ask that you contact your insurance company.

I.N._____

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Office Hours and Contacts

Office staff members work Monday through Thursday 9:00-5:00 and Friday 9:00-3:00. Office phones automatically turn off during lunch from noon-1:00. Office hours vary for each provider. Appointments must be scheduled in advance; walk-ins are not accepted.

The office phone number is (586) 466-5911 and fax is (586) 466-5921. If you would like to reach the front desk, please select option #1. If you would like to request a refill or have medication-related questions/concerns, please select option #2. If you are calling regarding insurance-related questions/concerns or other inquiries, please select option #3. Due to the high call volume we receive, we ask that you leave a voicemail on the appropriate line and your call will be returned within one business day.

I.N._____

Medication Management

All refill requests will be addressed within 48 hours during operating business days only. Refill requests will not be fulfilled during the weekend. Please request a refill before you run out of medication. All medication changes must be addressed with your medical prescriber during an appointment. All prescribers reserve the right to mandate therapy and drug testing if warranted.

I.N._____

Disability/FMLA

It is the nature of our business to treat patients with psychiatric/psychological/emotional needs. If your symptoms have caused a disability requiring completion of specific assessments/paperwork, we require several provisions. You must be an established patient and have appointments scheduled with both a therapist and medical prescriber. If assessments/paperwork is not completed by its due date, it is your responsibility to file an extension from your employer/HR or requesting firm. Extensive paperwork may be subjected to an additional fee.

I.N._____

Privacy and Confidentiality

Patient confidentiality is protected by ethical practice and Federal Law. However, there are exceptions that legally mandate our providers and staff to breech confidentiality: 1) the law requires the treating provider to notify appropriate personnel if a patient is judged to have intention to harm him/her/themselves or another; 2) the provider is obligated by law to report suspected child abuse or neglect; 3) in the event of a legal case, the clinical and therapy records may be subpoenaed by court.

Your health care information may be disclosed to other health care providers and staff within the clinic regarding treatment; to seek payment from your health plan or other sources of coverage (i.e. auto insurance); health care operations to support day-to-day operations, budgeting, financial reporting, and activities to evaluate and promote quality. Your health care information may also be disclosed via telephone and/or email, specifically for appointment reminders.

Other uses and disclosures that require your attention include disclosure of your health care information or its use for any purpose other than those listed above which require written authorization via a Release of Information form signed by you. We will not release any privileged personal health information without your consent and signed authorization.

I.N._____

As permitted by law, we reserve the right to amend or modify our office practices and policies. Said changes will comply with all federal and state laws. If any issues or concerns rise regarding the above policies, please file an official grievance with the office staff. Please state your name, date of service, your provider, and reason for grievance. You can also submit a letter outlining your concern(s) by mail addressed to: Management of Sher Psychiatry at 41400 Dequindre Rd, #107 Sterling Heights, MI 48314

I give Sher Psychiatry permission to diagnose and treat me. I will adhere to all office policies. If I am found to be in violation of these policies, I am subjected to probation and ultimate dismissal from the clinic.

Patient Signature_____ Witness_____