Henry C. Skinner, M.D.
Family Psychiatry of Maine, LLC
253 Main St
Yarmouth ME 04096
Phone 207-650-1393
Fax 888-538-7919

# TREATMENT AGREEMENT

I/We, _____ and _____,

bring my/our child _____to Family Psychiatry of Maine/Dr. Henry Skinner for evaluation and/or treatment of the following concern(s):

_____

_____.

**Right to Consent:** By my signature below, I/we certify that I am/ we are legally entitled to consent for medical treatment of this child, and that no other person is legally entitled, authorized or required to consent to this treatment. _____

**Alternatives:** I may expect that Dr. Skinner will explain his assessment and/or diagnosis and any further recommended diagnostic interventions, including the potential risks and benefits. I may expect that Dr. Skinner will explain the risks and benefits of the recommended treatments, including alternative treatments and no treatment. _____

**Therapy Risks:** I understand that Dr. Skinner may have ideas about my/our child's condition that are uncomfortable to discuss or with which I/we may disagree. Furthermore, I understand that treatment of children's issues usually involves other family members in addition to the identified patient. Treatment often requires behavioral change by both the child as well as other family members. It is possible that evaluation and treatment of family members other than the identified child may be recommended. I accept that the discussion and implementation of these changes may cause short-term emotional distress on the way to lasting improvement. _____

**Medication Risks:** All medications carry a risk of side effects as well as benefits. I may expect that if Dr. Skinner recommends medications, he will explain the risks, benefits and alternatives, including no medication. Dr. Skinner will inform me/us of common and serious side effects, but it is not practically possible to cover all possible side effects. If anything occurs that I am/we are concerned may be a side effect of the medication, I/we agree to call Dr. Skinner. _____

**Mandated Reporting:** I understand that Dr. Skinner is obligated by law to report any concerns of physical, sexual and/or emotional abuse and/or neglect to the appropriate authorities. The appropriate authorities have responsibility for evaluating and substantiating (or not) concerns of abuse. Furthermore, United States Supreme Court rulings require that if a patient makes a threat of violence against an identifiable individual, that person and the police in their jurisdiction are required to be notified. _____

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**Privacy and Confidentiality:** Both you and your child, if over 14, have a right to expect confidentiality in your relationship with the psychiatrist. Indeed, trust is a fundamental ingredient of a successful treatment. However, there are situations in which confidentiality may have to be breached.

1) In event that Dr. Skinner has a concern that abuse is taking place, he is required by law to report it to DHHS. It is up to DHHS to evaluate whether the concern is substantiated.
2) In the event that the patient or a family member makes a specific threat against an identifiable individual, the police are required to be notified.
3) In the event that a patient is at risk of significant self-harm or harm to others or is impaired by mental illness to the point that they are unable to adequately care for themselves, they may be involuntarily hospitalized. This would, of course, require notifying appropriate crisis resources, the ER, and the hospital. I/we may expect that Dr. Skinner will keep parents/guardians fully informed if he has concerns that a patient is at risk for such behavior.
4) The medical records may be subject to subpoena in the event of a legal action (in which case they would become of public record). _____

**Boundaries:** In order for effective treatment to take place, we can have only one kind of relationship: that of doctor and patient(s). We may have no other personal or business relationship. I do not accept gifts of any size or value. If you desire to express gratitude, positive online reviews are much appreciated. _____

**Contacting the clinic**: Dr. Skinner may provide established patients with an email address, but this is only to be used for practical and logistical, non-urgent issues such as appointment scheduling, billing, or medication refill requests. All discussion of clinical matters should take place in person or over the phone. Sometimes you will reach Dr. Skinner's confidential voicemail, and you should leave a message about your concern. Dr. Skinner will try to return the call within one business day. _____

**Emergencies:** If you are having an emergency during business hours, call me. If patients are having thoughts of dying, suicide, or self-harm, this is an emergency. If you get my voicemail and I do not call back within 10 minutes, or it is outside business hours, you should do one of the following:

- Call the crisis response hotline at 207-774-HELP (774-4357).
- Call 911
- Go to your nearest emergency Room _____

**Refills:** Patients/Parents/Guardians have a responsibility to keep track of their medication supply. Refill requests will be made 3 business days in advance, otherwise they may not get filled in time. _____

**Scheduling and Cancellations:** After the initial evaluation, scheduling is done at the time of the visit, by email, or by phone. Cancellations on less than 24 hours' notice will be charged 50%, unless a valid reason is presented. Only patients whose accounts are current may schedule new sessions. _____

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**Fees & Payments**: the basic rate is $275 per hour.

- Initial evaluation (90 minutes) is $400.
- 50 minute sessions are $275
- 25 minute sessions are $137
- Other services, such as participating in IEP meetings, are billed by the hour in 15 minute increments.

Checks, Cash, MasterCard, Visa and Discover Cards are accepted at time of service. A receipt will be provided for your records or for you to submit to your insurer for reimbursement. I am out-of-network for all insurers, except Anthem. Prior to scheduling an initial evaluation, you should use the Insurance Reimbursement Worksheet, found on the "Helpful Forms" page of my website, to find out how much your insurer will cover. _____

**For Anthem members only**: the above cancellation policy does not apply. Instead, clients who cancel on short notice or fail to show up 3 or more times may be discharged from the practice on 30 days notice. Anthem subscribers make their copayment at the time of the visit. By providing insurance information, you consent to have diagnosis codes sent to the insurance carrier for claims processing and you assign reimbursement to Family Psychiatry of Maine. _____

Signature of patient/parent/guardian: _____

Print Name: _____

Date: _____ relationship: _____

Signature of second parent/guardian: _____

Print Name: _____

Date: _____ relationship: _____

Henry Skinner, MD: _____ Date: _____