Henry C. Skinner, M.D.
Family Psychiatry of Maine, LLC
253 Main St.
Yarmouth ME 04096

Phone 207-650-1393
Fax 888-538-7919
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www.familypsychiatry.me

TREATMENT AGREEMENT

I, ____ hereby consent to

evaluation and treatment by Dr. Henry Skinner/Family Psychiatry of Maine for the following concern(s):

____

____.

Right to Consent: By my signature below, I certify that I am an independent adult legally entitled to consent for treatment , 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 condition that are uncomfortable to discuss or with which I may disagree. I accept that the discussion and implementation of these findings and recommendations 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 possible risks, expected benefits and alternatives, including no medication. Dr. Skinner will inform me of common and serious side effects which sometimes occur, but it is not practically possible to cover all possible side effects. If anything occurs that I am concerned may be a side effect of the medication, I 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 and/or neglect. 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. ____

Privacy and Confidentiality: You have a right to expect confidentiality in your relationship with your 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 the event that Dr. Skinner has a concern that abuse or neglect 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.

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2) In the event that the patient or a family member makes a specific threat against an identifiable individual, that individual and their local 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, the hospital.
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. We may have no other personal or business relationship. Dr. Skinner does not accept gifts of any size or value. If you feel a desire to express gratitude, positive online reviews are very much appreciated.______

Communications: 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. An email consent form which discusses the confidentiality risks of email is required. 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 it the same day, but sometimes it will have to wait for the next 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 have a responsibility to keep track of their medication supply. Refill requests should be made 3 business days in advance, otherwise they may not get filled in time.________

Scheduling and Cancellations: After the initial evaluation, scheduling can be 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. ______

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.

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- 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/BlueCross. 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 patients using Anthem insurance, copayment is expected at time of visit. The Cancellation fees above do not apply. However, patients who incur three or more short-notice cancellations or no-shows may be discharged from Family Psychiatry of Maine with 30 days notice to find a new provider. By providing insurance information, you consent to have diagnostic codes sent to your insurance carrier and you assign reimbursement to Family Psychiatry of Maine. __________

Signatures:

Signature of patient: ____

Print Name: ____

Date: ____________________

Henry Skinner, MD: ____ Date: __________________

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