RESILIENT MIND PSYCHIATRY
8701 Shoal Creek Blvd, Suite 404
Austin, Texas 78757
Phone: (512) 572-5340
Fax: (512) 229-0830

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PSYCHIATRIC SERVICE CONTRACT

Welcome to Resilient Mind Psychiatry!

Thank you for choosing our practice. Seeking treatment for a mental health concern and finding the right fit can be a challenging process. We are very pleased that you have given us an opportunity to work with you. We provide comprehensive high quality psychiatric care. Please read this document carefully as it contains important information about professional services, business policies, and the respective rights and responsibilities of both provider and client.

Please feel free to ask questions about the information below before you sign.

What to bring to the first visit.

- Current list of medications (please bring prescription bottles esp. for any controlled substances)
- Government-issued ID
- Signed copy of this psychiatric service contract

Please arrive 15 minutes early to the initial appointment

Services & Initial Consultation

We are licensed in the state of Texas to practice psychiatry, which includes prescribing medications, providing psychotherapy, or both, depending upon your particular treatment needs. During your initial visit, your provider will take a detailed history and make treatment recommendations based on the session, along with impressions of what our work together may entail. Please note that initial consultations are designed to help determine if the client and provider are a good fit for continued treatment. Successful treatment requires an active and committed approach by both the clinician and the patient, so it's important for you to consider whether you are comfortable working with your provider. As mentioned above, we do

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not prescribe controlled substances such as benzodiazepines (e.g. Xanax, Klonopin) or stimulants (Adderall, Ritalin) at the first visit.

Potential patients: Only non-clinical communications such as scheduling, rescheduling, and cancellations may be communicated.

ESTABLISHED PATIENT - PROVIDER COMMUNICATION

EMERGENCY COMMUNICATION:

For emergency issues including, but not limited to, risk of harm to self or others, call 911 or go to the nearest emergency department. Do not call the office for emergencies.

PHONE:

If you have non-emergent questions or concerns about your treatment, please call 512-572-5340. Please note that Dr. Mon does not take phone calls during appointments. You may leave a non-confidential voicemail or message with staff. To ensure that we can reach you in a timely manner, please ensure that your contact information is accurate and up-to-date. Dr. Mon checks phone messages daily and returns call within 2 business days, Monday through Friday, during office hours.

EMAIL:

Email communication will be via secured portal system only. Email communication is for non-urgent, non-emergency mental health-related questions, updates on your new medical condition, prescription by other providers, requesting refills, and routine administrative questions such as scheduling appointments or getting directions. We will not diagnose or manage psychiatric conditions via email. Email communication will be documented in your medical records if needed. Dr. Mon will respond to email within 2 business days, Monday to Friday during office hours. Depending on the time required to respond to the email, there may be a fee associated with email usage as per the payment policy below.

Unacceptable usage of email includes, but is not limited to,

- Communicating urgent or life threatening issues

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- Communicating non-medical or administrative issues
- Using profanity or harsh language
- Sending threatening messages

These unacceptable usages of email will result in termination of email privileges and potential termination of our professional relationship.

CONFIDENTIALITY

Trust and safety are paramount in the treatment of your mental health. We and all staff members take confidentiality very seriously. Federal law prohibits the release of any information about our work without your written permission, with a few exceptions:

1. If your provider believes you could harm yourself or others
2. If your provider suspects child or elder abuse
3. If a court subpoenas your records
4. If you are in an emergency department and emergency physician needs information to treat you appropriately

INSURANCE

Dr. Mon does not accept insurance. If requested, Dr. Mon can prepare a superbill for you to send directly to your insurance provider for potential reimbursement.

PAYMENT

Payment is due in full before each session and clients are required to keep a current credit card on file. We accept cash, checks, MasterCard, American Express, and Visa. There is a $40 charge for returned checks.

<u>Initial Psychiatric Appointment, 60 minutes: $350</u>

The first encounter will involve a comprehensive evaluation of 60 minutes. We will explore a thorough patient history including the reason for the visit, stressors, symptoms, past and present medical and family history, medications, allergies, social factors, and other relevant issues. Please fill out the new patient forms prior to the visit. We will then discuss the

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patient's concerns, diagnosis, prognosis, education, expectations, and treatment planning. A follow up plan will be established during this visit.

Follow-Up/Medication Management, 20 minutes: $160

We will plan an individualized approach to your psychiatric care together. During this 20 minute appointment, we will focus on changes since the previous encounter including progress of the condition(s), new psychosocial circumstances, possible side effects of medications, and changes in medication if needed, are considered. Further work-up (e.g. laboratory testing, neuropsychological testing, and consultation from another physician) will be ordered only if needed.

Follow-Up/Medication Management and psychotherapy, 45 minutes: $230

During this 45 minute appointment, we will work with both medication management and psychotherapy. First focus on previous encounter including progress the condition(s), new psychosocial circumstances, possible side effects of medications, and changes in medication if needed are considered. In addition, we will help to improve recognizing problematic behavior, come up with interventions to help the problems by optimizing emotional responses, thoughts, and interaction with others, and practice these interventions at home.

Other professional services (e.g. report writing, consultations, phone calls, and email):

Other professional services will be charged based on normal a clinical rate which is currently $350 per hour.

APPOINTMENTS AND CANCELLATIONS

Treatment is available by appointment only. Cancellations must be made at least 24 hours in advance by calling the office. Missing an appointment and/or failing to cancel within 24 hours of the appointment time will result in the full charge for the missed appointment. If this occurs, we will automatically charge your on-file credit card. Repeated no-shows or late cancellations may lead to discontinuation of treatment. Please arrive 15 minutes early to the initial appointment please be on time for all other appointments. If you are 15 minutes late to an appointment, you may need to reschedule the appointment and you may still be charged for the full visit.

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PRESCRIPTIONS AND PRESCRIPTION REFILLS

We are required to check the Texas Prescription Monitoring program to ensure avoidance of duplicate prescriptions of controlled substances. In the interest of safety, clients who take medications must be monitored by their provider to assess effectiveness and side effects. You will receive ample medication and refills until your next appointment. It is your responsibility to schedule follow-up appointments before your prescription runs out. Please note that we are conscientious about medical costs and do not request unnecessary visits. Medications refilled between visits typically provide the client with a quantity sufficient to last until the next appointment. We will not prescribe more than a 30-day supply of a controlled substance. Refills for triplicate medications (e.g. stimulants for attention deficit disorder) between appointments are completed for a $20.00 fee. We take great care to prescribe safely and effectively. In return, clients are expected to take medications as prescribed.

HOSPITALIZATION

Resilient Mind Psychiatry does not have hospital admitting privileges. If there is a crisis regarding your safety or others, you will be directed to and/or a mental health officer will escort you to the closet emergency department for evaluation and management. Dr. Mon will do her best to coordinate care.

TERMINATION OF OUR RELATIONSHIP

You may terminate our professional relationship at any time by providing us with notice. We may terminate our professional relationship at any time, subject to our ethical obligations and rules of the Texas Medical Board, by providing you with 30 days notice. We will provide you with a list of alternative providers. Altering a medication's dose without a provider's consult, sharing medication with others, or using them in a non-therapeutic way is a serious breach of provider-patient trust and may result in termination of the treatment relationship.

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- ☐ **I understand Resilient Mind Psychiatry does not accept any form of insurance.**
- ☐ **I understand I must provide valid credit card number to Resilient Mind Psychiatry at least 48 hours before the initial appointment.**

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☐ **I understand I must bring government-issued photo ID to the initial appointment.**

☐ **Resilient Mind Psychiatry is opted-out of Medicare. I understand that Resilient Mind Psychiatry will not reimburse fees from Medicare and/or Medicaid and I agree I will not seek reimbursement from Medicaid and/or Medicare. I understand I am seeking fee-for-service medical care which requires an active credit card to be on-file.**

☐ **I understand and agree that controlled medications are not generally prescribed and I will not get a new prescription or refill of controlled medications (e.g. Adderall or other stimulants, opioids, anesthetics, hypnotic sleep aids, Klonopin, Xanax or other benzodiazepines) on the first visit.**

I have read this Psychiatric Service Contract and understand it and agree to the terms and conditions. I consent to be treated and grant permission to Resilient Mind Psychiatry to perform examinations, procedures, provide advice, and treatment. I agree that I am financially responsible for all charges that I incur with Resilient Mind Psychiatry. I agree to pay all fees and charges at the time of service.

Patient Signature _____ Date _____

Patient Name (Printed) _____

Patient initial_____

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NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: We are required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how we are permitted to:

• Use and disclose PHI about you
• How you can access and copy that information
• How you may request amendment of that information
• How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so. We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

Uses and Disclosures of PHI: We may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI: **For treatment**. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport. **For payment**. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third- party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

2 **For health care operations**. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization: We are permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

• For our use in treating you or in obtaining payment for services provided to you or in other health care operations;
• For the treatment activities of another health care provider;
• To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
• To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
• For health care fraud and abuse detection or for activities related to compliance with the law;
• To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called an ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.

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AUTHORIZATION FOR RELEASE OF PROTECTIVE HEALTH INFORMATION

Name_____

Date of Birth_____

I give permission for the following agencies/persons to share my protected health information with: ***RESILIENT MIND PSYCHIATRY***

Name_____
Address_____
City_____State_____ Zip Code_____
Phone _____ Fax _____

Name_____
Address_____
City_____State_____ Zip Code_____
Phone _____ Fax _____

Name_____
Address_____
City_____State_____ Zip Code_____
Phone _____ Fax _____

□ All Records/Communication	□ Psychological Testing	□ Progress Notes
□ Verbal Communication	□ Medication Information	□ Psychotherapy Notes
□ Psychiatric Evaluation	□ Lab Tests/Medical Imaging	□ Alcohol/Drug Abuse
□ Others		

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Approximate Dates of Service:

☐ Any Time

☐ From: _____ To: _____

This authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used by the agency/person who receives it under this authorization. Unless cancelled or otherwise specified, this authorization will expire 10 years from date of signature.

Other Specified Expiration

_____

Patient Signature _____ Date _____

Patient Name (Printed) _____

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____,
authorize Resilient Mind Psychiatry to charge my credit card above for per policy rates. I understand that my information will be saved to file for future transactions on my account. This payment is for clinical visits and associated charges as noted in the policies of the clinic. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; as long as the transaction corresponds to the terms indicated in this form.

Patient Signature _____ Date _____

Patient Name (Printed) _____

Patient initial_____