**ADMINISTRATIVE AND/OR PENALTY FEES FORM**

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an **appointment/cancellation** policy. The policy enables us to better utilize available appointments for our patients in need of our care and to optimize your services.

1. **Cancellation/No Show Policy for Doctor Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment. Equally, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a what seemed to be a full appointment book.

**\* A no show" is someone who misses an appointment without cancelling it with at least 48 business hours of notice.**

How to cancel your appointment: If it is necessary to cancel your scheduled appointment, we require that you call at least 48 business hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. You may cancel the appointment by calling ((571) 278-6037 or 703 291 0260 during business hours of Mon-Friday 8am to 6pm, or by emailing info@novacamphealthservicesllc.com

1. **Scheduled *Appointments*/Tardy**

We understand that delays can happen, however we must try to keep the other patients and doctor on time. If you are running late, please notify the office by calling (571) 278-6037 or 703 291 0260 during business hours of Mon-Friday 8am to 6pm, or by emailing info@novacamphealthservicesllc.com

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| **Same Day Appointment Change/ Late Appointment/ No Show Fee $50.** |
| **If the patient is 10 minutes or more late to the scheduled appointment, you will need to be rescheduled and will be charged the same day cancellation fee.** |
| **Patient cannot schedule another appointment until we collect the $50 fee under no circumstances.** |
| **Form Completion of any kind $30 per page.** |
| **Medication Prior Auth $25 (This does not guarantee approval from ins.)** |
| **Any medical records releases to patient are $50.**  |
| **The patient is responsible to provide an active credit card on file.** **Credit Card Pre-Authorization Form must be completed.** |

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| **Patient Name:** | **Patient signature:** | **Date** |
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**INSURANCE BILLING AUTHORIZATION FORM**

This form authorizes GRACE HEALTH SERVICES LLC to use or disclose your patient health information to bill Medicare, Medicaid, CCS, or your private insurance company for evaluation and treatment of your medical/psychiatric conditions.

I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made on my behalf to GRACE HEALTH SERVICES LLC for services provided me by GRACE HEALTH SERVICES LLC, its agents, and employees. I authorize any holder of medical information about me to release to GRACE HEALTH SERVICES LLC, Medicare, Medicaid, CCS, and/or any other insurance company including its agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, its agents, and employees. This signature authorization shall remain in effect until revoked by me in writing.

I understand that GRACE HEALTH SERVICES LLC is HIPPA compliant and I have the right to request a copy of GRACE HEALTH SERVICES LLC’s Privacy Notice and to review it before signing this authorization form. A photocopy of this authorization is to be considered as valid as an original.

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| **Insurance Information** |
| **Primary** | Insurance Company: | Effective date: / / |
| Name of Insured:  | Policy/Member ID:  |
| Copay: $  | Subscriber Name/ID:  | Relationship:  |
| Group/Plan #: | Claims Address: | Phone: |
| **Insurance Information** |
| **Secondary** | Insurance Company: | Effective date: / / |
| Name of Insured:  | Policy/Member ID:  |
| Copay: $  | Subscriber Name/ID:  | Relationship:  |
| Group/Plan #: | Claims Address: | Phone: |

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| **BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT. THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.** |
| **Patient Name:** | **Patient signature:** | **Date** |
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**Credit Card Pre-Authorization Form**

The undersigned Patient/Cardholder hereby authorizes GRACE HEALTH SERVICES LLC, to obtain payment of fees for services from the Patient/Cardholder’s Credit Card account identified below.

GRACE HEALTH SERVICES LLC may charge the account to secure the patient’s appointment time, for any missed/late cancelled appointments (minimum of 48 hours cancellation notice is required), without requirement of the Patient/Cardholder’s signature for each payment. A receipt of the transaction will be mailed to the address provided by the Patient/Cardholder above.

You will be billed after your insurance has processed the claim and has sent us an Explanation of Benefits (EOB), telling us what services were billed, what amount was covered by the insurer, and what balance you owe. We will then send you an invoice outlining the details of your responsibility. We will then charge the credit card you have on file.

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| **Patient Information** |
| **Patient Name:** |  | Address:  |
| City: | State:  | Zip:  |
| **Credit Card Information** |
| **Name On Card** |  |
| **Credit Card Number**  |  |
| **CVV Number:** (3 digits on back of card – AMEX (4 digits on front) |   |
| **Expiration Date: (Month/Year):** |  |
| **Patient/Cardholder Authorized Signature:**  |  |
| **Printed Name of Authorized Signor:**  |  |
| **Credit Card Type:**  | [ ] Visa [ ] MasterCard [ ] American Express [ ] Discover  |
| **By signing this form, the Patient/Cardholder acknowledges and agrees as follows:**  |
| * The Patient/Cardholder authorize any balance to automatically be charged to this credit card.
* This signed form is confidential and will be kept on file at GRACE HEALTH SERVICES LLC.
* The Patient/Cardholder authorizes GRACE HEALTH SERVICES LLC to automatically charge the above-referenced Credit Card.
* The Patient/Cardholder certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.
* Credit Card payments will appear on your statement as GRACE HEALTH SERVICES LLC.
* If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees that the charges are valid and agrees not to dispute said charges. § This authorization will remain valid for 12 months or until revoked in writing with 30 days notice of revocation.
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| **Patient Name:** | **Patient signature:** | **Date** |
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**Telepsychiatry Contract and Informed Consent**

**\*PLEASE READ THIS DOCUMENT CAREFULLY**

This document serves as a consent form for the use of telepsychiatry for the provision of psychiatric treatment. Telepsychiatry involves the use of video conferencing software with audio capability and/or a separate software/device for audio (e.g. telephone, headset, etc.) to establish a formal provider-patient relationship for the purposes of assessment, diagnosis, therapy, and/or prescription. The Health Insurance Portability and Accountability Act (HIPAA) will be used to protect the confidentiality of the patient's protected health information.

**Benefits of telepsychiatry include:**

1. Improved accessibility to behavioral health services for patients who may have limited accessibility or encounter long waiting lists in the community.

2. Reduced burden of travel time and associated costs and risks.

3. Greater flexibility in scheduling appointments.

4. Increased privacy for treatment in the patient's personal space.

5. Improved access to treatment for patients with disabilities or limited mobility.

**Limitations of telepsychiatry include:**

1. Potential technical difficulties with audiovisual equipment.

2. Increased risk of security breaches due to the electronic nature of the appointments.

3. Inability to treat certain illnesses that require a higher level of care.

4. Some illnesses may not be adequately treated through telepsychiatry.

5. Federal law prohibits the prescription of controlled substances through telepsychiatry due to the potential for addiction, abuse, and illegal diversion. Safer alternatives may be considered.

**Safety protocols and alternate treatment options will be discussed in detail during the consultation. However, some general alternatives to telepsychiatry include:**

1. In-office visits with another provider.

2. The patient has the right to withdraw their consent for treatment via telepsychiatry at any time, although it is recommended to discuss this decision with the psychiatrist and establish a new provider prior to termination to avoid gaps in treatment.

At every visit, the patient's name, location, and telephone number will be recorded to ensure that the psychiatrist is aware of alternative means of treatment in case of an emergency. The provider and the patient have the following rights and responsibilities:

1. Prior to the prescription of any medication, a physical examination by the patient's primary medical doctor is required.

2. The provider reserves the right to assess the suitability and appropriateness of telepsychiatry for each patient due to the potential limitations of the treatment modality.

3. In the event of imminent danger, the provider is required by law and ethics to report the necessary information to authorities, hospitalization, or other appropriate resources.

4. The provider has the right to terminate treatment if the patient is not compliant with the treatment plan or if the patient exhibits dangerous or threatening behavior towards the provider or others.

5. The patient has the right to receive treatment that is respectful and sensitive to their cultural and individual needs.

6. The patient is responsible for disclosing any relevant information to the provider, including changes in their physical or mental health and any medication changes.

7. The patient is also responsible for following the treatment plan as agreed upon with the provider.

*By signing this consent form, the patient acknowledges that they have received and understand the information provided about telepsychiatry and that they have had the opportunity to ask any questions. The patient also gives their consent to receive treatment via telepsychiatry and agrees to the rights and responsibilities outlined above.*

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| **Patient Name:** | **Patient signature:** | **Date** |
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