INSIGHT

PSYCHIATRY

Policies and Procedures

Name:_____

Address: _____

Phone: _____ **Date of Birth:** _____

Emergency Contact: _____ **Phone:**_____

We welcome you to Insight Psychiatry LLC. We prepared the following information so that you may have a clear understanding of our policies concerning fees, insurance, confidentiality, and other common policies and procedures.

Consent to Treatment

I, _____, agree to receive treatment from Dr Jill Husson Martinez, MD through Insight Psychiatry LLC. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

Patient's Signature: _____ Date: _____

Fee Schedule & Good Faith Estimate (No Surprises Act)

The physician's fee will vary depending on the service rendered and are listed below. Insight Psychiatry LLC is a fee-for-service practice and does not take Medicaid-Medicare nor any other private insurance. However, we will provide a receipt for services rendered that can aid clients submit claims to their health insurance company. It is important to note that submitting a claim to your insurance company does not ensure full or even partial coverage, given that it's dependent on the type of insurance plan/coverage clients carry. Please note: We can only accept one form of payment (cash, personal check, or credit/debit card). We cannot split payments. Payment for services is due in full at the time of your appointment.

- Initial psychiatric consultation (60-90 minutes) $350

- Ongoing psychotherapy and medication management (50 minutes) $275
- Medication management with focused psychotherapy (25 minutes) $175
- Form completion (e.g. FMLA) $50 per form

Insight Psychiatry LLC requires **at least 24 hours notice for appointment cancellations & rescheduling**. If patients cancel or reschedule appointments less than 24 hours before the originally scheduled time, Insight Psychiatry LLC reserves the right to charge the full fee for the canceled/rescheduled appointment.

In compliance with the No Surprises Act that went into effect January 1, 2022, all healthcare providers including psychiatrists and therapists are required to notify patients of their federal rights and protections against "surprise billing." The purpose of the Act and of this document is to protect you from unexpected medical bills.

This Act requires that you be notified of your federally protected rights to receive a notification when services are rendered by an out-of-network psychiatrist, if you are uninsured, or if you elect not to use your insurance.

In case any of these situations apply to you, we are required to provide you with a "Good Faith Estimate" of the cost of services to you. Doing so is particularly challenging in mental health care because it is difficult to predict the length of treatment, and because patients have a right to decide how long they want to participate. Therefore, described above are the fees that typically apply for the types of services offered, including for your condition. Going forward, we can collaborate on a regular basis to determine how many sessions you may need.

- The fees listed above apply to all DSM diagnostic codes of the American Psychiatric Association.
- The diagnostic codes used are clinically accurate, but these do not guarantee reimbursement.
- Most often therapy is done once weekly, but sometimes more or less often.
- Most often therapy continues for six months, one year, or several years, but short-term, brief therapy for intercurrent issues is also common. As noted above, because of this variability, please ask about what can be expected in your case.
- Most often medication management is done every three months, but sometimes more often at the beginning of treatment and during periods of acuity, and sometimes less often.
- Most often medication management continues for several years or even longer; because of this variability, please ask what can be expected in your case.
- It is your right to determine your goals for treatment and how long you want to remain in therapy.

Required Disclaimers:

- Should you have additional questions about your rights under this act, you can contact any of the following: The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit <https.//www.cms.gov/nosurprises> for more information about your rights under federal law.

- If you are billed for more than this Good Faith Estimate you have the right to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 days (about 4 months) of the date on the original bill.
- There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the healthcare provider, you will have to pay the higher amount.

Patient's Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's signature:_____ Date signed:_____

Forensic Matters

Insight Psychiatry LLC may be required by law to disclose confidential information in certain cases. The following are examples:

1.) If we assess that our patient is a clear and present danger to himself/herself or another person, appropriate others may be notified to prevent that occurrence.

2.) If there is reason to suspect that child or elder abuse has occurred, the law requires that it be reported to the proper authorities.
3.) In a legal proceeding, the Judge may order disclosure of information they feel would be necessary for the proper administration of justice.

In the event that Dr Martinez is subpoenaed to appear in a court action involving the care that was delivered to you or to a family member, you will be charged that clinician's standard fee ($1000 per hour) for court appearances. Even if the subpoena is not issued by your attorney, but rather by an adverse party, you will be charged for and expected to pay the clinician's fee for these services. This fee includes the clinician's time in preparing for court, appearing in court, preparing reports, communicating with attorneys, etc.

Please note that Insight Psychiatry LLC does not participate in custody evaluations, permanent disability evaluations, nor does Dr Martinez serve as an expert witness in court cases.

Patient's signature:_____ Date signed:_____

Communication Guidelines

1. In the event of an emergency, I will go to the nearest hospital or call 911 for assistance. Once I am getting assistance, I will notify Dr. Martinez by leaving a voicemail. Please do not include emergency events in an email.

2. I agree to only call and/or email between 8 am and 9 pm Monday through Saturday. Phone conversations will be limited to less than 10 minutes and will be reserved for administrative issues such as rescheduling an appointment.

3. I will use email for concise communication of administrative issues. It will not be used as a substitute for an appointment or to make treatment recommendations.

4. If I need to express lengthy thoughts, raise issues, or discuss symptoms in written form, I understand that Dr. Martinez will print the email and it will be discussed in our next session. Dr. Martinez does not respond to therapeutic content in writing, as it does not serve the therapeutic process responsibly.

5. I understand that voicemail is checked once every 24 hours Monday through Saturday. Voicemail and email are not checked on Sunday.

6. Text messaging will not be used.

7. I will not include Dr. Martinez in mass emails.

I have read and agreed to these communication guidelines.

Patient's signature: _____ Date signed:_____

Controlled Substance Agreement

In the event that my treatment requires the use of controlled substance(s), I adhere to the following:

1. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substances that might impair my judgment.
2. I will not obtain any controlled medication from another medical provider without informing this practice, Insight Psychiatry LLC, of the circumstances involved. This includes pain pills, muscle relaxers, anti-anxiety, or stimulant medications.
3. I will notify my medical provider of any new health concerns I have even if not obviously related to my treatment.
4. I will not be involved in the sale, transport, or sharing of any controlled substance or medication.
5. I will safeguard my medication from loss or theft. I will carry only the amount of medication I need, in the prescription bottle, for the time away from home, leaving the rest in a safe place.
6. I will not take larger or more frequent doses than what is written on the prescription bottle.
7. I will not ask for early refills.
8. In the event that I am arrested or incarcerated related to legal or illegal drugs, I will not be given any refills of controlled substances. I understand that my involvement in such activities could result in termination of care from Insight Psychiatry LLC.
9. If I am female, I understand that if I become pregnant, or if I am suspicious that I am pregnant, I will notify my provider immediately.
10. I agree to use only one pharmacy for obtaining controlled medications. I am to notify my provider if I wish to change pharmacies and this must be done prior to requesting any refills.
11. I agree to comply with urine drug toxicology screening if ordered by the physician.
12. I understand that the physician will be checking the state prescription drug monitoring database routinely and if aberrant prescribing and/or dispensing practices are noted, my prescriptions may be discontinued.

I have read this document and agree to the guidelines. If I had any difficulty understanding the content, I have asked for clarification. If my prescription(s) is/are not helping to improve my daily life, I will report this to my provider. I understand that if this agreement is not followed, I may be discharged from this practice.

Patient's signature:_____ Date signed:_____