

SCHEDULED APPOINTMENTS

What to bring to your initial evaluation appointment:

Your initial appointment will consist of a consultation to explain your diagnosis and treatment options. Please assist us by providing the following information at the time of your consultation, if applicable:

- A completed NEW PATIENT FORM PACKET
- If you have medical insurance, cards issues by the insurance company are required to be scanned into the system.
- Social Security Number of the insured is **required**.
- A government-issued picture ID is **required**.
- A list of prior treating physicians, psychiatrists, psychologists and therapists.
- Any information on any laboratory tests, procedures, or images completed in the past six months.
- If you have medical insurance, bring the cards issues by the insurance company.
- Your preferred form of payment. ***For your convenience you can have your credit card information stored in your electronic file.*
- **You must bring in all prescription bottles before any refill of a controlled medication prescribed by a previous provider will be issued / continued. Under no circumstances will our office refill medications without medication bottles, pharmacy reconciliation or records being received directly from your previous providers office.**

What to bring to your follow-up appointment:

- A list of any treating physicians, psychologists, or therapists that you started to get treatment or were treated since your last visit at our office.
- An information on any laboratory tests, procedures, or images completed since your last visit at our office.
- Your insurance card must be provided at each visit.
- Your current form of payment. ***If you have your credit card information stored in your file, please make sure that its expiration date is current and updated in our system.*

Telemedicine Follow up Appointment:

Before appointment:

- Please make sure you can connect to doxy.me link through the clinic website.
- Make sure to test the link and doxy.me platform before your appointment. **If you are unable to get the equipment to work, it is your responsibility to get a hold of the office the day before your appointment to make sure that your equipment is functional and works with the system.** If you are unable to be contacted through the system, not in the virtual waiting room, or for any other reason unable to get your system to work prior to your appointment, it will be considered a late cancel / no show and you will be responsible for any applicable fees.
- Please make sure to send in any screening tools applicable to your individual care and conditions 24 hours before your appointment. If this paperwork is not received, your appointment will need to be rescheduled and considered a late cancel or a no show and you will be responsible for applicable fees.
- Please make sure to email any medication changes and any information on any laboratory tests, procedures, or images completed since your last visit to alicia@bthealthcareclinic.com brittany@bthealthcareclinic.com or melissa@bthealthcareclinic.com
- Please make sure the office has your updated insurance card 24 hours before your appointment. *****Please text or email a copy of your updated insurance card 24 hours before your appointment. If your claim is not paid by insurance, the balance will become your responsibility.***
- Please make sure the office has your current form of payment. *****If you have your credit card information stored in your file, please make sure that its expiration date is current and updated in our system.***

Supplemental Consents

This consent to treatment represents my consent to medical and psychiatric treatment provided to me or my ward by Bonne Terre Healthcare Clinic LLC (BTHC) and all healthcare professionals working in collaboration with the practice. I voluntarily authorize the examinations, tests and procedures customarily performed on patients with my condition and consent to customary treatments as ordered by the providers, including medication treatment. I also consent to drug testing if deemed appropriate by my practitioner. **If a controlled medication is prescribed, a urine drug screen will be required monthly.** This consent remains in place unless it is withdrawn by appropriate party.

_____Initials

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made by any of BTHC providers, employees, or affiliates, to the results of treatment or examinations.

_____Initials

I understand that medications may be prescribed by BTHC provider for the treatment of my or my ward's condition. I recognize that I have the right at any time to ask more questions regarding the treatment. I also recognize that it is my responsibility to clarify any treatment decisions my provider has recommended. I also recognize that if I have further concerns, it is my responsibility as a patient or patient's representative to voice those concerns. I also agree that if I accept and take a medication, I am responsible for understanding risks vs. benefits of those medications and if I take a medication I am consenting to treatment and accept all risks of treatment as well as potential interactions with other treatments. If I accept off-label treatment, I acknowledge that I have the right to ask for alternative treatments that are not off-label and I understand that taking an off-label medication means I am consenting to all the risks associated with taking a medication not labeled or studied for my condition.

_____Initials

I understand that vitamins may be offered by BTHC provider for the treatment of my or my ward's condition. I understand that supplements are frequently not regulated by the FDA. I understand that frequently supplements may interact with medications in a way that is not fully understood. I also recognize that it is my responsibility to clarify any treatment decisions the provider has recommended. I also recognize that if I have further concerns, it is my responsibility as a patient or patient's representative to voice those concerns. I also agree that if I agree to a treatment with a vitamin/supplement, I am responsible for understanding risks vs. benefits of those supplements and if I, or my ward, take a vitamin/supplement, I am consenting to treatment and accept off-label treatment, I acknowledge that I have the right to ask for alternative treatments that are not off-label and I understand that taking an off-label vitamin/supplement means I am consenting to all the risks associated with taking a medication not labeled or studies for my condition.

_____ Initials

I understand that treatment compliance is extremely important. **I understand that by not making follow up appointments, not taking prescribed medications regularly, or not discussing with treating practitioner the personal decision I make regarding the way I am taking my medications, could result in adverse effects to my health up to and including death.**

I recognize it is my responsibility to notify the provider of any concerns or changes I believe are necessary for my (or my ward's) treatment plan. It is also my responsibility to make sure the provider knows what changes have been made by other treatment providers. I recognize that it is my responsibility to document my concerns or health changes and address them with the practitioner.

_____ Initials

I have read or have had read to me this consent and understand and agree to its contents. I understand that the consent for medical treatment, authorization for release of information and assignment of financial responsibility will be valid for the duration of treatment and can only be revoked upon written notice. By initialing below, I acknowledge that this consent form has been read in full and explained as necessary.

_____ Initials

MEDICATIONS MANAGEMENT

Medication Refill Policy: You must notify us **during your visit** of any and all prescription refills needed before your next visit. **Medications will be prescribed at the time of appointment, and you will always be given enough medication and refills until the next office visit, so refills are not necessary over the phone if you are following your agreed upon treatment plan.** This is to limit medication errors and to protect your safety. **If you have missed or cancelled an appointment, you will need to schedule another visit and will be provided with enough medication until the re-scheduled visit, within 1-2 weeks of the missed appointment.** **Psychiatric medications are not automatically refilled through pharmacy request system. You must contact the clinic on your own behalf to request renewal and schedule your next appointment. This clinic does not respond to pharmacy requests for medication renewals.**

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Refill of controlled substances: Prescriptions for **controlled substances** (opioid replacement or benzodiazepines) **will not be reissued** until three calendar days before the date the prescription is due to run out. **You are responsible for safeguarding your prescriptions and medications.** **
It may be wise to request a carry bottle from the pharmacy to allow you to carry a few pills with you as you travel or are out of the home.

_____ Initials

NOTE REGARDING OUR BENZODIAZEPINES PRESCRIBING STRATEGIES: We care about your overall safety, health and longevity. We expect all patients to be willing to gradually wean themselves off benzodiazepines over time and to acquire other healthier coping mechanisms.

_____ Initials

PAYMENTS AND INSURANCE

Payment policy: Payment in full of all applicable charges is due when the service is rendered. If you are unable to provide the payment of all applicable fees, your appointment will be rescheduled. For your convenience, our office accepts major credit cards, cash or personal checks. We do not accept post-dated checks. There is a \$25 fee for checks returned for insufficient funds. Patients with balances over \$150 must either pay the balance or make payment arrangements prior to future appointments being made.

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Insurance: Our company is an “in network” provider for most major insurance carriers and for Medicare and Medicaid. Before you come in for an appointment, please check with your insurance carrier regarding the amount of co-payment that you will be charged for our service. As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. **If the patient fails to provide us with the correct information, they are financially responsible for the office visit charges. Please remember, any amount not covered by insurance is ultimately the patient’s responsibility.** The required co-payment cannot be waived, as doing so may violate our contract with your insurance carrier. We accept “out of network” benefits from most out-of-state insurance plans.

_____ Initials

No Call / No Show / Cancellation: I understand and agree that if I do not show up or call at least 24 hours before an appointment to cancel or reschedule, I will be charged a fee according to Bonne Terre Healthcare Clinic LLC policies. I understand that this fee is not covered by my insurance and will be billed directly to me as it is my sole responsibility. This fee must be paid prior to being seen for subsequent services.

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TELEPHONE POLICY

We make every effort to answer your call; however, there are times when heavy call volume may prevent us from speaking with you. Due to high call volume, it is important that you follow these instructions:

- Please do not call more than once a day for the same issue.
- Please allow up to 24 business hours for a return call, especially if you call late in the day.
- Medical issues will not be addressed over the phone. Please make an appointment.
- Office staff will be polite and respectful to you and we expect the same in return.
- Calls may be recorded for quality control purposes.
- Abusive or incessant calls are cause for termination from our practice. All threats are reported to the proper authorities.

Call in Policy: to uphold the quality of care and in fairness to all our practice patients, our providers cannot take time out of their scheduled appointments to accept or return patient phone calls. If you need to be seen before your scheduled visit, be prepared to provide brief details to staff about what makes this a crisis. **If you feel you must speak with your provider, please make an appointment to allow them to give you the care and attention you deserve.**

FMLA/LEGAL/OTHER MEDICAL PAPERWORK HANDLING AND CHARGES

Routine school or work excuses are available upon request at the end of your appointment.

If time permits, brief forms (less than 5 min) may be completed during your allotted appointment time and there will be no additional charge. Longer forms and letters will be done outside of appointment time and the fees will be based on the time involved to complete this service.

Please see below:

Simple (less than 5 minutes) No Charge.

Moderate (5-15 minutes) \$35.00.

Lengthy (15-30 minutes) \$55.00

Complex (over 30 minutes) \$100.00

Upon written request, records will be copied. It typically takes a week to have copies made.

Copies of charts will be mailed directly to the requesting entity.

The fee for copying is:

\$25.51 preparation/handling fee

\$0.59 for each copied page

Payment of \$50.00 for the copied documents must accompany the written request. Refund of overpayment will be placed into the patient's account. Any additional charge (for over the 20 page) file will be billed separately.

MEDICAL RECORDS

Mental health records are a standard practice in psychiatry. They are protected by both law and professional standards. While you are entitled to review a copy of your record, they can occasionally be misinterpreted given their professional nature. In rare instances when it may be deemed potentially damaging for our clinicians to provide you with the full records, we can ensure that they are made available to an appropriate mental health professional of your choosing. They will need to provide us with a written record request accompanied by the Release of Information form personally signed and dated by you or your guardian. Please note that professional fees will not be charged for any preparation time requested to comply with such requests.

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TERMINATION POLICY

It is the policy of this practice to establish and maintain a cooperative trust-based provider/patient relationship. Should the relationship, trust or mutual goals of the provider and patient not be realized, either party may terminate the relationship within the bounds of applicable state and federal laws, rules and regulations.

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PRIVACY POLICY

Use of recording devices by a patient is prohibited unless approved in advance in writing.

Violators are subject to termination. The form, Notice of Privacy Practices (Long Form), presents the information federal law requires us to give our patients regarding our privacy practices. The notice is a pdf document which requires Adobe Reader Software. It is most likely you already have this software on your computer; however, if you have difficulty you can download the Acrobat Reader for free online.

_____Initials

CONFIDENTIALITY

Confidentiality is a cornerstone of mental health treatment and is protected by the law. Aside from emergency situations, information regarding your care and treatment can only be released with your written permission. If you are seeking insurance reimbursement, insurance companies also often require information about diagnosis, treatment, and other important information as a condition of your insurance coverage. They may occasionally request some of your medical files as you have given them permission to access this information when you signed an insurance contract with them.

_____ Initials

There are legal exceptions to confidentiality that may require us to disclose the information about you:

- (1) Danger to yourself – if there is an explicit threat to harm yourself, our staff is required to seek hospitalization for the patient or to contact family members or others who can help us provide your protection or aid in your hospitalization if necessary.
- (2) Danger to others – if there is threat by you of serious bodily harm to others, our staff is required to take protective actions, which may include notifying the potential victim, notifying the police or any other appropriate authorities.
- (3) Grave disability – if, due to a mental illness, you are unable to meet your basic needs, such as clothing, food and shelter, our staff may have to disclose information to your family members or the proper agencies in order to help you access to help meet those basic needs.
- (4) Suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person – even if it is about a party other than yourself – our staff must file a report with the appropriate state agency.

- (5) Certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a subpoena.

Although these situations can be rare, our staff will make every effort to discuss the proceedings accordingly. We reserve the right to consult with other professionals or with our legal department when appropriate. In these circumstances, *your identity will not be revealed*, and only important clinical information will be discussed. Please note that such consultants *are also legally bound to keep this information confidential*.

_____Initials

AI Consent

The clinic has an integrated scribe assistant to help develop clinic encounter notes. By signing below, I acknowledge that I have read and understand the information about the use of AI-assisted documentation tools. I voluntarily consent to their use during my appointments. I understand the participation is voluntary, I can opt-out at any time, and I have had the opportunity to ask questions about the process, which have been answered to my satisfaction.

_____Initials

AFTER HOURS / EMERGENCY CALLS

p. (573) 723-1100

A member of our staff will be available to answer questions after business hours for **issues that cannot wait** until the office re-opens. **These calls should be limited to content that cannot wait until the next business day.** These calls should be limited to non-life-threatening issues as life-threatening issues or issues requiring stabilization should be handled by EMS and the emergency department (ED). If you have a medical emergency, please dial 911 or go to the nearest ED for evaluation and treatment as the afterhours phone would not be appropriate.



If you use the afterhours line for issues that are non-life-threatening but cannot wait until the office re-opens, you may be billed for a visit.

_____Initials

I have reviewed and understood the information above.

Printed Name

Signature

Date

Witness

Date