Milwaukee Psychiatrists & Psychologists Chartered

Marie Ferber, MD * Makenzie Hatfield, MD * Eric Kanter, MD * Tracey Latza, PsyD * Sally Lohs, MD
Marina Tierney, PsyD * Patrick Triggiano, PhD * David Wandschneider, PhD

12760 W North Ave, Bldg. A., Brookfield, WI 53005-4628 * Office: (262) 439-5500 * FAX: (866)439-5221
www.milwaukeepsychiatric.com

PATIENT INFORMATION:

Name:_____ Sex:_____ Date of Birth:__/____/_____ SSN:_____
Last First Middle Initial

Patient Address: _____
Street City State Zip code

Home Phone Number:(___)_____ Mobile Number:(___)_____ Email Address:_____

EMERGENCY CONTACT:_____Phone(___)_____Relationship:_____

PREFERRED PHARMACY:_____ Pharmacy Phone:(___)_____

GUARANTOR INFORMATION (Person responsible for payment):

Name**:**_____ Date of Birth:__/____/_____ SSN:_____
Last First Middle Initial

Address: _____
Street City State Zip code

Phone Number:(___)_____ Email Address:_____

MILWAUKEE PSYCHIATRISTS & PSYCHOLOGISTS CHARTERED IS NOT GUARENTEEING YOUR PHYSICIANS IS IN YOUR INSURANCE PLAN. PLEASE CHECK WITH YOUR INSURANCE COPANY.

INSURANCE INFORMATION-PRIMARY

Policy Holder Name:_____Relationship:_____ Policy Holder SSN:_____

Policy Holder DOB**:**_____/_____/_____Policy Holder Phone Number:(___)_____

Policy Holder Address:_____
Street City State Zip code

Insurance Name:_____Insurance Phone Number:(___)_____

Member ID:_____ Group Number:_____

Effective Date: ____/_____/_____ Policy Holder Employer:_____

INSURANCE INFORMATION-SECONDARY

Policy Holder Name:_____Relationship:_____ Policy Holder SSN:_____

Policy Holder DOB**:**_____/_____/_____Policy Holder Phone Number:(___)_____

Policy Holder Address:_____
Street City State Zip code

Insurance Name:_____Insurance Phone Number:(___)_____

Member ID:_____ Group Number:_____

Effective Date:____/_____/_____ Policy Holder Employer:_____

FOR PATIENTS NOT USING INSURANCE:

I, _____ agree to be responsible for all fee for services provided for me (or my child, if guarantor) by MPPC. I do not want MPPC to file any claims with any insurance company for services received.

CANCELLATION AND MISSED APPOINTMENT POLICY

Patients must notify the office at least 24 hours in advance if they need to cancel or reschedule an appointment. At the discretion of the provider, failure to provide adequate notice may result in a charge commensurate with the usual and customary fee for the scheduled appointment. This charge will not be covered by insurance and will be the responsibility of the patient or guarantor. Repeated late cancellations (less than 24 hours' notice) or three missed appointments may result in dismissal from the practice. Please note: leaving a voicemail is an acceptable form of notification.

Signature:_____ Date:____/_____/_____
(Patient, Parent or Guardian)

My signature above indicates that I have provided accurate information to the best of my knowledge.

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AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I hereby authorize Milwaukee Psychiatric Physicians Chartered (MPPC) for evaluation and treatment of myself or my child. I authorize MPPC to provide my insurance company or their representatives with information concerning my (or my dependent's) illness, injury and/or treatment necessary for completion of claims for insurance benefits.

PAYMENT POLICIES

Payment is expected at the time of service. If you have insurance coverage, we will submit charges to the insurance on your behalf, but co-pays are to be paid at the time services are rendered. Services performed outside of the office, including, but not limited to, court appearances, depositions, school visits, extended telephonic/electronic communication, etc., cannot be billed to insurance and therefore any fees related to these services will be your responsibility. Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary. MILWAUKEE PSYCHIATRIC PHYSICIANS CHARTERED IS NOT GUARANTEEING THAT YOUR PROVIDER IS IN YOUR INSURANCE PLAN. PLEASE CHECK WITH YOUR INSURANCE COMPANY.

In divorce situations, the parent that brings the child to the appointment is responsible for payment of charges including co-payments, *regardless of divorce decree*. If payment issues exist, they must be resolved between the parents.

I understand that I am responsible for the portion of fees not paid by insurance. If the account becomes delinquent, I understand that it may be sent to collections and interest may be charged.

PRIVACY, RIGHTS AND RESPONSIBILITIES

I received the Notice of Privacy Practices. It explains how health information is handled.
Medical records may be shared with health providers and insurance companies for treatment, payment and health care operations, with written consent of the patient or guardian.

I am legally able to consent and give my permission for treatment. My signature below indicates that I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.

Patient's Name (Printed): _____

Signature: _____

Relationship to patient: _____ Date: _____

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Authorization and Payment Policy

By signing below, I give permission for Milwaukee Psychiatrists & Psychologists Chartered (MPPC) to collect my credit or debit card information at checkin and enter it directly into a secure, encrypted, tokenized payment system. My full card number will not be stored in the patient portal or electronic health record. I authorize MPPC to charge my card for any amounts I am responsible for, including copays, deductibles, session fees, and balances not covered by insurance.

MILWAUKEE PSYCHIATRISTS & PSYCHOLOGISTS CHARTERED DOES NOT ACCEPT PATIENTS WITHOUT A VALID CREDIT CARD ON FILE.

Telehealth Billing

I understand and agree that:

- A valid credit or debit card on file is required before all telehealth appointments
- My card will be charged after my telehealth visit has occurred
- Charges may include copays, deductibles, coinsurance, or noncovered services
- If I do not provide a valid card, my telehealth appointment may be delayed, rescheduled, or cancelled

Outstanding Balances

Please select one:

☐ Yes, I authorize MPPC to charge the card on file for outstanding balances instead of receiving monthly statements.

☐ No, I do not authorize MPPC to process charges on the card on file and request monthly statements. I understand payment is required within 30 days of billing.

Past Due Policy

If any balance becomes more than 90 days past due, MPPC may process the payment using the credit card on file. The patient may also call to set up a monthly payment plan. Please call our billing office at 2624395500 option 3 for more information.

Agreement: By signing below, I confirm that I understand and agree to the terms outlined above.

_____

Patient Name:

_____ _____

Signature: Date:

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I, _____ [name of patient] hereby consent to engaging in telemedicine at Milwaukee Psychiatrists & Psychologists Chartered as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data and psychoeducation using interactive audio, video or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Wisconsin. Telemedicine has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that telemedicine may be experienced somewhat differently than face-to-face treatment sessions.

Video/Audio Recording: As a general practice, Milwaukee Psychiatrists & Psychologists Chartered DOES NOT record telemedicine sessions without prior permission.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only. I agree to have my credit/debit card information on file with MPPC. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, MPPC will cancel my appointments and I will be charged in accordance with the cancellation policy.

Client using insurance: I am responsible for contacting my insurance company, if applicable, to determine coverage and what out-of-pocket costs will be.

Self-Pay clients: I am aware that the fees associated with telemedicine appointments are the same as if I were present in the office for a face-to-face visit.

Scheduling: I understand that scheduling is conducted through MPPC and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency services or crisis services.

Client's Right, Risks and Responsibilities:
I understand that I have the following right with respect to telemedicine:

1. I, the client, have the right to withhold or withdraw consent at any time.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment at MPPC.
3. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my doctor, that the transmission of my medical information could be intercepted, disrupted or distorted by technical failures. In addition, I

understand that the telemedicine-based services and care may not be as complete as face-to-face services.

4. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telemedicine. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my telemedicine sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telemedicine session. It is the responsibility of the provider to do the same on their end.

5. I understand that telemedicine does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

I have read and understand the information provided above. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____

Client Signature Date

_____ _____

Client Guardian's Signature Date

_____ _____

Provider Name & Signature Date

Please return to:

Email: info@milwaukeepsychiatric.com

U.S. Postal Address: 12760 W North Ave, Brookfield, WI 53005

MILWAUKEE PSYCHIATRISTS & PSYCHOLOGISTS CHARTERED MEDICATION REFILL POLICY

Milwaukee Psychiatrists & Psychologists Chartered have developed the following guidelines regarding medication refills. If you or your child receive medication that has been prescribed by one of our physicians, it is essential that you become familiar with these guidelines.

- **You must be seen in the clinic by your physician on a regular basis in order to continue receiving medication refills.**
- Requests for medication refills will be done during normal office hours only and may take **48-72 hours to process.**
    - Refills needed by Friday must be submitted by 4:00 PM Tuesday and those needed by Monday or Holiday Tuesdays must be submitted by 4:00 PM on Thursday.
- Please **call your pharmacy** for any refills even if the bottle says "NO MORE REFILLS". The pharmacy will then contact the office for authorization of the refill.
- Only your treating physician will refill your prescriptions. In a medical emergency, the on call physician may refill a prescription but the quantity of the medication will likely only be enough to last until the treating physician returns.

Please plan ahead and do not wait until the last minute to request a refill for your medication. The following is a list of helpful reminders:

- Some medications cannot be refilled over the telephone. The written prescription must then be picked up at our office by 6:00 PM Monday thru Friday.
- Some insurance companies require prior authorization for some prescribed medications. If your insurance company requires prior authorization, it may take additional time for the medication to be refilled.
- You are responsible for telling your prescribing physician when you stop or start a medication prescribed in this clinic or elsewhere. Doing so will assist your physician in monitoring your medication and will ensure that you do not run out.