Marie Ferber, MD * Makenzie Hatfield, MD * Dustin Hejdak, MD * Eric Kanter, MD * Tracey Latza, PsyD * Sally Lohs, MD
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12760 W North Ave, Bldg. A., Brookfield, WI 53005-4628 * Office: (262) 439-5500 * FAX: (866)439-5221
www.milwaukeepsychiatric.com

PATIENT INFORMATION:

Name:____ Date of Birth: ____/____/______

Address:____
Street City State Zip Code

Home: (_______)___________________ Cell: (_______)___________________ Work: (_______)_________________

Sex: Male______ Female______ Email Address:____

SSN:______________________________ Employer: ____

Emergency Contact: ____ Phone: (___) __________________
Name Relationship

PREFERRED PHARMACY:____ Phone: (_____)_____________________

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT)

Name:____ Date of Birth: ____/____/______

Address:____
Street City State Zip Code

Home: (_______)___________________ Cell: (_______)___________________ Work: (_______)_________________

Email Address:____

SSN:_______________________________ Employer:____

FOR PATIENT NOT USING INSURANCE:

I,____ agree to be responsible for all fees 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.

INSURANCE INFORMATION—PRIMARY

Insurance Name:_______________________________________ Phone: (_____)___________________________

Insured's Name:______________________________ Relationship:_____________ Employer:_________________

Insured's Address:____
Street City State Zip Code

Insured's Date of Birth:____/____/______ Insured's SSN:____

ID/Policy #:______________________________ Group #______________________ Effective Date: ____/____/______

INSURANCE INFORMATION—SECONDARY

Insurance Name:_______________________________________ Phone: (_____)___________________________

Insured's Name:______________________________ Relationship:_____________ Employer:_________________

Insured's Address:____
Street City State Zip Code

Insured's Date of Birth:____/____/______ Insured's SSN:____

ID/Policy #:______________________________ Group #______________________ Effective Date: ____/____/______

CANCELLATION AND MISSED APPOINTMENT POLICY

Notification is required 24 hours prior to the appointment. Lack of notification will result in an $85-$110 missed appointment fee, depending on the time duration of the scheduled appointment. This charge will not be covered by insurance and will be the responsibility of the patient or guarantor. If you cancel your appointment with less than 24 hours' notice and/or miss appointments, you may be subject to discharge from the physician's practice. Please note, leaving a voicemail is an acceptable form of notification.

MILWAUKEE PSYCHIATRISTS & PSYCHOLOGISTS CHARTERD IS NOT GUARANTEEING YOUR PHYSCIIAN IS IN YOUR INSURANCE PLAN. PLEASE CHECK WITH YOUR INSURANCE COMPANY.

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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CREDIT CARD INFORMATION

It is our policy to collect credit card information from all patients or their responsible parties and to maintain this information on file in a HIPAA compliant and confidential manner.

We require that insurance co-payments be paid at the time of your visit. If a patient is not able to pay their co-payment at the time of their visit with cash or check, we will use the credit card on file to process the payment for them.

If a patient becomes more than 90 days overdue, with any balance, we will process the payment for them using their credit card information or they may set up a monthly installment plan. Please contact our billing office at 262-439-5500 option 3 for more information.

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

Patient Name:
____

Cardholder Name:
____

Cardholder Zip Code: _______________________________________

Credit Card Type: VISA______ MasterCard______ Discover______

Card #:
____

Expiration Date: __________Month/__________Year V-Code: ____________________________
(3 or 4 digit security code)

I authorize MPPC to run balances on this credit card instead of receiving monthly statements: Y N
Please circle

Signature of Card Holder:_______________________________________Date:_______________________

*****WE DO NOT ACCEPT AMERICAN EXPRESS*****

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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.