A-1 Behavioral Health Services
Regain control

3740 North Josey Lane, Suite 213,
Carrollton Texas 75007
(972) 656-8258

(Providers: Joy Ichie MSN, APRN, PMHNP-BC , Pavan Pamadurthi, MD -Collaborating Psychiatrist)

Practice Policies, Procedures and Patient Treatment Agreement

This patient treatment agreement and practice policies and procedures have been adopted to facilitate an appropriate and efficient treatment for patients of A-1 Behavioral Health Services. In order to provide you with the best mental health treatment experience, please read and sign the practice policies and procedures agreement.

I, _____, fully understand that treatment in this practice involves my complete participation, and that while under the care of my provider, I must abide by the following policies which will be consistently enforced:

OFFICE HOURS:

Our office hours are Monday through Thursday: By appointment only.

Friday: 9am – 5pm

Saturday: 9am to 2pm.

We are closed on Sundays and on major holidays.

Telepsychiatry visit option is available upon request.

- During bad weather days, our office will be closed if the local schools are closed. Scheduled appointments will be rescheduled during those occasions, but you have an option to be scheduled to be seen via Telepsychiatry during business hours on bad weather days if indicated.

COMMUNICATION:

Phone calls/emails - Phone calls are only received during office hours. We do not accept after hours phone calls, but you can leave a message for your calls to be returned during business hours. When leaving a message, please state your full name and phone number. Non urgent phone calls are returned within 48hours.

- Please call 911 for life threatening situations/emergencies or go to the nearest emergency department.

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Another way to communicate with our provider is by sending an email using the HIPPA compliant email platform on our website (A-1Behavioralhealth.com). Emails will be answered in 24 to 48hrs. A-1 Behavioral health Services uses phones, email, text messaging, electronic health messaging systems and other forms of communication for different clinical operations. We use encrypted and HIPAA compliant platforms. We recommend that you protect your private information by protecting your means of communication using passwords and pins when needed.

_____ I agree that A-1 Behavioral health Services, may contact me by telephone, electronic messages, mail or cell phone as provided by me or person on my behalf or that are identified as mine later. I understand that these communications may be from this provider and/or those providing services within the practice of, or on behalf of, this provider including communications about the scheduling, treatment or payment for services rendered. These calls include but are not limited to using an automatic telephone dialing system, artificial or prerecorded voice or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service. I understand that my agreement to the terms of the Patient Consent and Assignment of Insurance Benefits is not a condition of willingness to provide treatment to me. I consent to all the authorized communication methods even if I will incur a cost to receive such communications.

For **Telepsychiatric services**, visits will be held using video conferencing software with audio capability and/or a separate software/device for audio (e.g, telephone, headset, etc.). Telepsychiatry establishes a formal provider-patient relationship used to maintain regular assessment, diagnostics, therapy, and/or prescription. Health Insurance Portability and Accountability Act (HIPAA) protected software will be utilized to ensure that your protected health information is secure from unauthorized access and that confidentiality is maintained. This document serves as a consent form for treatment via telepsychiatry in general.

I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the relevant entity.

INSURANCE: FEES/PAYMENT

We accept and are in-network with some insurance companies. Call the office to verify if we are in network with your insurance. We accept self-pay for those who desire to pay by cash only.

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- A current insurance card must be presented at the first visit and when your insurance changes. If not, you will be responsible for the self-pay rate of the appointment. You are responsible for notifying the office in a timely manner of any changes in your insurance plan.
- Insurance co-payments, if any, are due on the day of scheduled appointment.
- If A-1 Behavioral Health Services is not contracted with your insurance carrier or your visit is a non-covered service, you are responsible for the charges. Please note that you are responsible for medical expenses regardless of insurance coverage.

_____ I authorize my insurance benefits to be paid directly to A-1 Behavioral Health Services and I recognize my responsibility to pay for all non-covered services, including any additional cost incurred in collecting these amounts. I also authorize A-1 Behavioral Health Services to release any information necessary to process my insurance claim. If my insurance fails to make a payment to A-1 Behavioral Health Services, I understand that I am responsible for the fees and this will be charged to my credit card. I understand that if I choose to self-pay, payment is also due on the day the services were provided.

- For self-pay Options - You are expected to pay in advance of the visit. We accept cash, debit or credit cards and do not accept check payment.
- Your credit card will be validated prior to payment being processed and we will collect your payment/fees online or in-person prior to each scheduled office appointment.
- Our fees are $250 for a new evaluation and $95 for follow ups, $150 for individualized therapy sessions with medication management. There is a $10.00 fee for declined credit cards. Unpaid balances are charged a late fee of $20.00/month. These fees are subject to change.

_____ I understand that if I fail to pay for services received, unpaid balances will be sent to a collection agency and that my services will be terminated. Also, all billing information such as name, address, place of employment, dates of service received, and all required information needed to process payment may be given to a professional collection agency to use for debt collection. I further understand that if my account is placed for collection, I will be responsible for the fees and all additional related fees charged by the collection agency.

APPOINTMENTS AND APPOINTMENT CANCELLATIONS:

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- New patients – You are expected to arrive at our office not later than 15 minutes before your scheduled appointment time to allow adequate processing time of your information. Failure to do so may result in your appointment being re-scheduled.

- Follow up patients – You should arrive at least 5 minutes before your appointment time in order to be ready for their scheduled appointment. For late arrival, you may be given an option to wait to be seen later depending on the number of people who are ahead of you or the availability of an open slot. Late arrival after 15 minutes to your scheduled appointment will require your appointment to be rescheduled for another day.

- Scheduled appointments require at least 24 hours cancellation notice. If an appointment is not cancelled or rescheduled without adequate notice, there will be a charge of $50 which will be billed directly to you and must be paid before your next appointment. This charge cannot be covered by your insurance. Appointments not cancelled or rescheduled less than 24 hours in advance will be considered a no call/no show appointment. After three (3) no call/no-show appointments, you will be discharged from the practice. We will send an appointment reminder one day before your scheduled appointment. Please respond to that voicemail or text so we will know if you intend to keep or cancel the appointment to allow us time for planning in case you intend to cancel. Please note that it is your responsibility to cancel an appointment on time to avoid a no-show charge.

LABS:

Sometimes you may be required do routine and maintenance lab monitoring based on your treatment needs. Please note that lab services are not included in your office visit charges. You are responsible for verifying the lab charges and making payment when indicated. The office will not be responsible for lab charges incurred.

MEDICATION REFILL IN BETWEEN APPOINTMENTS

We strive to ensure that you are given enough medication and refills to last until your next appointment. You are responsible for keeping your appointment and informing the office if you missed an appointment and need medication refilled. Refill request outside of appointment times or in between appointments are subject to a **$20 fee**. Please note that **NO REFILLs** will be issued to controlled substance in between appointments. All lost scripts for controlled medication will require a police report before a new one is issued.

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For medication refills in between appointments, please leave your name, phone number, name of medication and the phone number of your preferred pharmacy with reason for the refill request. About **7-10 days** may be required to refill medication. Prescription scripts will only be called in for those who are active clients and keep their regularly scheduled appointments in the past 6 months.

MEDICATION PRIOR AUTHORIZATION:

Each insurance carrier has formulary medications that they cover and for certain medications, a prior authorization may be required to be completed by your provider for the medication to covered by your insurance. Please note that if your insurance requires a prior authorization for a medication, the process could be time consuming and may not be completed until end of each business day.

TESTIFYING IN COURT

At A-1 Behavioral Health services, we do not involve ourselves in custody or divorce cases or other legal matters that may require testimony or civil matters as Our providers do not testify in court. However, If any legal action occurs that requires your provider at A-1behavioral health Services to testify in court including any subpoena sent by the opposing party, please note that you will be responsible for all travel expenses including an hourly fee of $100.00 that would be incurred from the time the provider leaves the clinic until the provider returns to the clinic. At least 50% of the estimated fee is due prior to the court appearance. This is true for both active and non-active clients.

MEDICAL RECORDS:

If you are requesting a copy of your medical record you must fill out a written request. Please allow at least 14 business for your record request to be processed. The cost for medical records is $20.00.

COMPLETION OF FORMS

We do not complete FMLA/Disability paperwork except in very rare cases. If indicated, there will be a charge of $100.00 as these charges are not covered by insurance companies or your employer. These forms of paperwork are usually time consuming and need to reflect your records. We require that you give at least a two- week period to complete the form. Only patients who have been seen at the practice for at least 12 months will be assisted with a FMLA/Disability paperwork.

- For other forms or letters regarding flying and or airline tickets and letters to employers, charges will incur, and amount varies depending on the amount of time required to process or complete the letter or form. The client will always be notified of any charges ahead of time and payment will be required prior to the release of the requested forms or letters.

MEDICATION MANAGEMENT

Please understand that we will provide you with a full assessment of your diagnosis and medication needs. You may find that a change in medications or diagnosis may be needed sometimes based on evaluation. You may not always be guaranteed to be provided the same medications that you have previously taken. Decision on the right treatment options is made in collaboration with your provider. Our goal is to provide you with quality, holistic and evidence-based treatment approach, and we promise to provide support, the right treatment and work with you as you regain control over the challenges of mental illness. We want to see you function at your optimal capacity and thrive again.

SCOPE OF PRACTICE:

We do not provide benzodiazepine type medications or psychostimulants, except in very carefully selected cases and only for a very brief period. In cases where psychostimulants are required, the prescriptions must be submitted to the pharmacy by a medical doctor and will require a ten (10) day notice for any of these types of prescriptions. Prescriptions for controlled substances cannot be called in and must be picked up. We focus our treatment on other well researched equally effective non-benzodiazepines and non-stimulants treatment options.

CONDUCT DURING OFFICE VISIT - Please do not use your cell phone during your scheduled appointment times. We will not tolerate disruptive behavior in the office. Disruptive behaviors include but not limited to the use of profane, vulgar language, shouting, yelling at staff, provider, other patients or any other person in the office or any threatening or disrespectful behavior in any form either in person or through phone, text messages, email and other means. Behaviors perceived as threatening or hurtful will be reported to the appropriate authorities and the person will be prosecuted to the full extent of the law of Texas and appropriately.

RIGHT TO REFER OR WITHDRAW: TERMINATION OF SERVICES

Treatment at A-1 Behavioral Health Services is voluntary. If for any reason your provider at A-1 Behavioral Health Services determines that their expertise does not fit well with your needs,

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you will be referred to a provider that is better suited for your needs and situation. The provider and/or client has the right to withdraw from treatment. Should the provider feel the need to withdraw, the client will be notified and provided with appropriate referrals and resources for continuity of care. Clients may terminate services at any time.

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CONFIDENTIALITY:

A-1Behavioral Health Services will not share your information with anyone without your authorization to release of the information for that individual. We are committed to protecting your privacy to the full extent of the law of Texas. However, there are certain situations when we as healthcare providers are required to report by law without your authorization. Such situations include if there are any evidence or suspected child abuse either in the past or present, If an individual has thoughts or plans hurt self or others, any form of sexual misconduct from another provider of any kind, certain court orders or custody matters, malpractice, or other court issues and for Collection of fees. Should you have any concern about these conditions, please feel free to speak to us and we will be happy to assist you.

POLICY ACCEPTANCE

At A-1 Behavioral health Services, we want to be part of your life journey and hope to establish and maintain a lasting, trusting therapeutic relationship while treating you with compassion and respect. If you have any questions about any of the procedures/policies, please ask and remember this policies and procedures as you receive services here.

This is an agreement between you, the client or responsible party of the client and A-1 Behavioral Health Services. By signing this agreement, I agree that I have read the above policies and procedures, understand, and agree to abide by all the policies and procedures stated within. I have been given the opportunity to ask questions and clarifications have been made.

*Signature*_____
Date: _____

If signed by another person for a minor, state relationship to the patient

_____

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Treatment Consent

You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment. This consent form is to obtain your permission to perform the evaluation necessary to identify appropriate treatment.

You have the right to discuss the treatment plan with your provider regarding the purpose, potential risks, and benefits of any treatment recommended by your provider.

I certify that I have read and fully understand the above statements and consent to treatment.

_____

Printed name of patient

_____

Signature of patient

If signed by another person for a minor, state relationship to the patient

_____

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Notice of Privacy Practices

When you receive treatment from A-1 Behavioral Health Services, We receive, create and maintain information about your health, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities.

We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation.

We may use and disclose your health information without your authorization to contact you for the following activities, as permitted by law and agency policy: providing appointment reminders; describing or recommending treatment alternatives; providing information about health-related benefits and services that may be of interest to you; or fundraising.

We may also use and disclose your health information without your authorization for the following purposes:

- For public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medical device issues to the FDA;
- To comply with workers compensation laws and similar programs;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if the agency reasonably believes you are a victim of abuse, neglect, or domestic violence

we will make every effort to obtain your permission, however, in some cases we may be required or authorized to alert the authorities;

- For health oversight activities such as audits, investigations, and inspections of DSHS facilities;
- For research approved by an Institutional Review Board or privacy board; for preparing for research such as writing a research proposal; or for research on decedents information;
- To create or share de-identified or partially de-identified health information (limited data sets);
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order;
- For law enforcement purposes such as identifying or locating a suspect or missing person;
- To coroners, medical examiners, or funeral directors as needed for their jobs;
- To organizations that handle organ, eye or tissue donation, procurement, or transplantation;
- To avert a serious threat to health or public safety;
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and for other law enforcement custodial situations;
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and
- As otherwise required or permitted by local, state, or federal law.

Additional privacy protections under state or federal law apply to substance abuse information, mental health information, certain disease-related information, or genetic information. We will not use or share these types of information unless expressly authorized by law. We will not use or disclose genetic information for underwriting purposes.

We will always obtain your authorization to use or share your information for marketing purposes, to use or share your psychotherapy notes, if there is payment from a third party, or for any other disclosure not described in this notice or required by law. You have the right to cancel your authorization, except to the extent that we have taken action based on your authorization. You may cancel your authorization by writing to the privacy officer per below.

YOUR PRIVACY RIGHTS

Although your health record is the property of DSHS, you have the right to:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.
- Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to the A-1 Behavioral Health Services office, or in person.

OUR DUTIES

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post revised notices on our public website at www.dshs.texas.gov and in waiting room areas. You may request a copy of the revised notice at the time of your next visit.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by contacting: DSHS Consumer Services and Rights Protection/Ombudsman Office by mail at Mail Code 2019, P.O. Box 149347 Austin, TX 78714-9347; or by telephone at (512) 206-5760 or (800) 252-8154 (toll free); and Office for Civil Rights, Region VI, U.S. Department of Health and Human Services, by mail at 1301 Young St., Suite 1169, Dallas, Texas 75202; or by telephone at (800) 368-1019, (214) 767-0432 (fax), or (800) 537-7697 (TDD).

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PATIENT INFORMATION

DATE: _____

Patient's Name: _____

(First) (Middle) (Last)

How do you wish to be addressed? _____ Marital Status: _____

Address: _____

(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Birthdate: _____ SS# _____

Employer: _____ Occupation: _____

Years Employed: _____

If Patient is a Minor (under age 18), name of parent or guardians _____

Referred By: _____

(Name) (Relationship)

RESPONSIBLE PARTY

Name: _____

(First) (Middle) (Last)

Marital Status: _____ Driver's License# _____

Address: _____

(Street) (City) (State) (Zip)

How long at this address? Relationship to Patient: _____

Previous address (if less than 3 years):_____

(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Birthdate: _____ SS# _____

Employer: _____ Years Employed: _____

Occupation: _____

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SPOUSE INFORMATION (if applicable)

Name: _____

(First) (Middle) (Last)

Birthdate: _____ SS# _____

Employer: _____ Years Employed: _____

Occupation:_____

INSURANCE INFORMATION

Primary Insured Policy Holder Name: _____

(First) (Middle) (Last)

Birthdate: _____ SS# _____

Employer: _____ Group #: _____

Insurance Company Name: _____Member Services Phone #:_____

EMERGENCY INFORMATION

In case of emergency, call: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____

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INITIAL PSYCHATRIC ASSESSMENT

THIS SECTION TO BE COMPLETE BY PATIENT OR PARENT (IF PATIENT IS A MINOR)

_____ _____ _____/_____/_____

PATIENT NAME (PRINT) AGE TODAY'S DATE

_____ _____

PERSON COMPLETING THIS FORM (PRINT) RELATIONSHIP TO PATIENT

_____

THERAPIST OR COUNSELOR'S NAME, ADDRESS, PHONE NUMBER

_____

PRIMARY CARE PHYSICIAN'S NAME, ADDRESS, PHONE NUMBER

REASON FOR EVALUATION: (IF PRESENT, RATE 0-10. 0 IS ABSENT, 10 IS EXTREME)

____ANXIETY____PANIC____DEPRESSION____MOOD SWINGS____SUICIDAL THOUGHTS

____SUICIDE ATTEMPT____AGITATION____AGGRESSION/VIOLENCE

____BEHAVIORAL PROBLEM____IMPULSIVITY____SCHOOL PROBLEMS

____RELATIONSHIP PROBLEMS____BIZZARE THOUGHTS____CONCENTRATION/FOCUS

____TASK COMPLETION____UNUSUAL OR STRANGE BEHAVIOR

____SLEEP PROBLEM____DRUG/ALCOHOL

BRIEFLY DESCRIBE PROBLEM: _____

_____

_____

_____

_____

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PREVIOUS TREATMENT? _____THERAPY? WITH _____

WHOM?_____

EVER HOSPITALIZED? ____ HOW MANY TIMES? ____ WHEN? _____

WHERE? _____

ON MEDICATION NOW? (NAME, DOSAGE, HOW LONG TAKEN, RESPONSE?) _____

_____

_____

_____

HERBALS OR SUPPLEMENTS? _____

MEDICATIONS USED IN THE PAST? ____Y ____N

NAME OF MEDICATION(S), DOSAGE(S), RESPONSE TO

EACH_____

_____

MEDICATION ALLERGIES?

_____

ANY MEDICAL PROBLEMS? _____

_____

HEIGHT _____ FT. _____ IN. WEIGHT _____ LBS.

DO YOU HAVE EXCESSIVE THIRST?____EXCESSIVE URINATION? ____

SUBSTANCE USE? (LIST ANY SUBSTANCES USED, PAST OR PRESENT, LAST USE)

_____

_____

_____

FAMILY HISTORY: (ANY BLOOD RELATIVES YOU BELIEVE HAVE HAD SYMPTOMS OF A PSYCHIATRIC OR
SUBSTANCE ABUSE PROBLEM)

_____

_____

_____

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_____

_____

LIVING SITUATION: (WHO LIVES AT HOME?)

_____

_____

_____

EDUCATION LEVEL:

CURRENT GRADE LEVEL (MINORS) _____

ACADEMIC PERFORMANCE ____ BELOW AVERAGE ____ AVERAGE ____ ABOVE AVERAGE

EDUCATION COMPLETED (ADULTS):

____ HIGH SCHOOL ____ GED ____ HOURS COLLEGE

____ COLLEGE GRADUATE ____ POST GRADUATE DEGREE

EMPLOYMENT _____