**Ilardi Psychiatric Services, LLC**

**Maria Ilardi, MSN, ARNP-BC**

Welcome, and thank you for choosing Maria Ilardi, ARNP to assist you with your behavioral healthcare needs. Please read the following policies carefully, and feel free to ask for clarification if you should have any questions.

**Treatment Agreement**

**CONTACTING ME:** I check my voicemail daily on days when I am in the office. I will make every effort to return non-urgent calls during my regular office hours. If your call is urgent, you may call my cell phone (785)766-0056. If you are having an emergency, please call 911 or go promptly to an emergency room for assistance. If you have a therapist, please call your therapist for all non-medication related calls. If I am away I may have another ARNP or psychiatrist checking my voicemail and covering for me. I do not respond to emails due to concerns about internet privacy. Please leave all messages on my voicemail. You may also call the numbers listed below for additional help: Headquarters Counseling Center 785-841-2345; Bert Nash Mental Health Center 785-843-9192; Suicide Prevention Hotlines: 1-800-suicide (784-2433) or 1800 273—TALK (273-8255).

**CANCELATIONS**

If you need to cancel any appointment, please do so at least 24 hours in advance, or you will be charged a $50 late cancelation /missed appointment fee. Please be aware that insurance companies will not reimburse this fee.

**BILLING AND PAYMENTS**

Payments, including all co-pays and deductibles, are due in full at time of service. If you are charged for a late canceled or missed appointment as described above, full payment must be made before your next appointment will be scheduled. Returned checks are subject to a $25 return check fee. Your first billing statement will be sent at no charge. After that, I will assess a $5 statement fee. If payments are not made on your account balance for 90 days, a $50 collection fee will be assessed, and your account will be turned over to a collection agency. Accounts turned over will be responsible for collection costs, including but not limited to collection fees, court costs, and attorney fees.

**INSURANCE REIMBURSEMENT**

At this time I am contracted with a small number of insurance companies. If you have an insurance that I do not contract with, you will have to pay for services in full. You will be given a statement of my services so that you may request reimbursement from your insurance provider. However, your insurance agreement is between your insurance company and you. I make no claims of my agreement with any particular insurance company.

I will bill Medicare and insurance companies that I have contracted with for services provided, and if possible obtain payment for these services, but I make no representation, guarantee, or warranty, that your particular treatment will be paid for by third party entities and have no way of knowing in advance the terms, conditions, deductibles, exceptions and exclusions of your individual policy. Some services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Insurance companies make no guarantee that the benefit information given is a guarantee of payment for services rendered. If your insurance company does not pay your account in full within 90 days of your treatment date, the balance will automatically be transferred to you. It is your responsibility to obtain any pre-authorization required by your insurance prior to the visit. If you do not obtain the required authorization, you will be financially responsible for any services provided. By signing this agreement you are authorizing payment of insurance benefits to Ilardi Psychiatric Services, LLC and understand that you are financially responsible for any charges not paid by insurance. You authorize Ilardi Psychiatric Services, LLC to release any information required to process any and all claims for reimbursement on your behalf. Please be aware that Medicare, Blue Cross Blue Shield and some other insurance companies will not pay for more than one service (i.e. doctor’s appointment, or therapy appointment) in a day. **If you see another doctor or therapist in the same day that you see me, you will likely have to pay my full fee out of pocket**.

**LIMITS ON CONFIDENTIALITY**

All communications between us are privileged and confidential. In almost all situations, I only release information about your treatment if you sign a written Authorization form in advance. **Your signature on this Agreement provides consent for these:**

* Consultation with other health and mental health professionals about your situation. Any other professionals I consult are also legally bound to keep our consultation confidential.
* When I am out of town, another clinician who is providing coverage for me may have access to your clinical records.
* If you should threaten to harm yourself or others, I may be obligated to seek hospitalization for you, or contact family members or others who can help provide protection.
* I may use fax machine to correspond with those with whom I have been given written permission to consult, and may use a cell phone or cordless phone. I cannot insure confidentiality of communication on cell or cordless phones.

In a few rare situations, I could be required to disclose information without your authorization:

* If a court orders me to do so.
* If a government agency requests the information for health oversight activities.

There are some situations in which I am legally obligated to take action without your consent:

* In cases of child or elder abuse or neglect
* If you make a specific threat to harm a specific individual, either someone else or yourself.
* If you are not able to provide for your own self-care because of a mental illness.

I make every effort to fully discuss any obligatory release of information with you in advance, and I limit this to what is legally necessary. If you have questions about confidentiality, please ask me.

**PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your clinical record. You have a right to your records if you wish. If you choose to exercise this right, I recommend that we review the record together, so that I can help interpret it for you. I can also prepare a summary for you if you wish. You will be charged for time spent responding to requests for such information. If you request records for sessions that have included another person such as your partner or child, I am required to block out any part of the record that pertains to anybody but you.

**Prior Authorization/Quantity Overrides/Non-formulary Issues**

Some Insurance companies limit availability or access to certain medications. These types of restrictions are between you and your insurance company. I have no way to know what these restrictions are when I prescribe a medication. If you learn that such a restriction exists, you may call me to discuss if there are any possible alternative medications, or you will need to contact your insurance company and have them fax me a written request, if clinical information from the prescriber is required to get approval for medication coverage. You will be required to provide your insurance company with medication history, ID numbers, etc. If you feel you are unable to handle this time-consuming communication with your insurance company, I will provide this service for a fee of $25 per request.

**Termination Policy**

Patients are under no obligation to continue services and may terminate services at any time; however, I strongly urge you to seek my advice prior to stopping medication so you can do so safely. If either of us determine at any point that I am not the best clinician to address your problems, I will make every effort to find an appropriate referral. If you fail to make or keep a follow up appointment for a period of six months or greater, I will conclude that you have terminated the patient- nurse practitioner relationship.