Polices & Procedures

Business Hours: Monday/Tuesday/Wednesday 8:00am - 6:00pm, Thursday/Friday 8:00am. – 5:00pm

Business Phone: (210) 582-6440 **Prescription Refill Line**: (210) 582-6407

Fax Number: (210) 692-9021 **Billing Office:** (210) 582-6452

Southwest Psychiatric Physicians offers these services: Medication follow-up appointments

To better serve our patients, we have developed the following guidelines:

(IN) _______ **Documentation:** Please complete all documents needed in order to process a new patient. If you have a situation that is not applicable, please indicate it by using N/A. Failure to complete our office documents may determine our ability to accept you as a patient. If you need assistance completing these documents, please indicate it to the outpatient receptionist and she will be happy to assist you. Your doctor will share with you a treatment plan with the recommended services and frequencies for you or your child. Services, which may not be covered by your insurance company, may include, but are not limited to: disability evaluations, custody evaluations, treatment mandated by a court, or other third party, or court appearances/depositions. Please be advised that some insurance companies only support medication evaluations and medication monitoring.

(IN) _______ **Payment:** Payment in full is expected at the time of appointment, regardless of any custody agreements or divorce decrees. If needed, our office will furnish you with a receipt of payment in which you can furnish to another financially responsible party. Our office does not handle disputes for payment between responsible parties. Our contracts and agreement with insurance companies and health plans require us to collect co-payments and deductible amounts at each appointment. Patients are required to pay any balances acquired after the insurance payments. If needed, payment arrangements can be made with the outpatient business office by calling (210) 582-6452. Accounts that are 90 days past due, may be subject (or sent) to collections.

(IN) _______ **Patient Tardiness:** The physician reserves the right to reschedule a patient that is more than 10 minutes late for an appointment. If the physician decides to see the patient for the appointment, the patient may need to wait to be seen later that day.

(IN) _______ **Cancellations & No Shows:** An appointment, which is missed without 24-hour notification of a cancellation, is considered a “No Show” appointment. You must leave a message with greater than 24-hour notice for any cancellations. A $20.00 fee may be charged for cancellations and/or no shows within the 24-hour period from your appointment. Your insurance will not pay for missed appointments. If you have two consecutive cancellations and/or no shows, we will assume that you no longer require or desire services. A letter for termination of services will be mailed to you.

(IN) _______ **Provider Cancellations:** Occasionally, your physician may need to cancel or reschedule appointments with you. If the physician is ill, you will be notified of this as far in advance as possible. We will discuss with you your options for medication refills if needed.

(IN) _______ **Copies of Records:** If you would like to obtain a copy of your psychiatric record, an Authorization for Release of Information form must be signed. If applicable, the requesting party will be responsible for any fees. Psychiatric records requests will be processed within 15 business days. If you need psychiatric records released the same day, there will be an additional $15.00 speedy processing fee. Due to HIPAA regulations regarding confidentiality, we may need to request additional information from the requesting party, such as copy of divorce decree, custody documentation, valid ID and/or other information before we can release copies of a psychiatric record. Fees for copies of records start at $25 for pages 1-20, then .50 cents per page thereafter.

(IN) _______ **Letters or Forms:** Request for letters, forms, or documents to be written by a psychiatrist may be subject to a fee. Consent for release of information will be required.

(IN) _______ **Restricted Access:** Due to the potential for conflict and/or misuse of confidential patient information, we reserve the right to restrict or deny access to any individual not involved in direct care with the psychiatrist or nurse practitioner.

(IN) _______ **Court Appearances:** A subpoena may be required for court appearances. The individual requesting the court appearance will be responsible for any fees incurred. All fees for the court hearing must be paid in advance. This also applies to depositions and other court-related matters. For more information, please discuss with SPP staff.

(IN) _______ **School documents:** School medication forms and/or other school forms will be completed at no charge. An Authorization for Release of Information is required. School forms may be faxed to (210) 692-9021. An SPP staff will contact you once these forms are completed. We encourage you make your requests at least a week in advance due to the doctor's availability.

(IN) _______ **Patient Advocate:** If for any reason you are not satisfied with your physician or if you have a complaint about any Southwest Psychiatric Physicians staff member, please contact the Clinic Coordinator at (210) 582-6450.

(IN) _______ **Nurse Practitioners:** Nurse Practitioners are required to have a designated supervising physician and are unable to order Schedule I & II controlled substances. For this reason, if you or your child are being seen by one of our Nurse Practitioners and are recommended to take a Schedule I or II controlled substance, it will be sent to your pharmacy by the Nurse Practitioner's supervising physician.

(IN) _______ **Refills:** If the prescription is **not** a controlled medication, **contact your pharmacy for any prescription refill requests**. Prescriptions that are needed **in between** office visits may be charged **$5.00 per patient**. We encourage you to call in your refill request at least **a week** in advance since it may take up to **7 business days** for processing. If you need faster service, there will be a **$15.00 charge** for speedy refill processing. The patient may need to wait for the doctor to become available to process the speedy refill. **Refills may be refused for patients who have missed an appointment. An appointment may need to be scheduled before any refills can be given.** Prescription Refills Policy: If your prescription is a controlled medication, we ask that you call (210) 582-6407 and follow the directions on the recording. Please do not leave incomplete messages, as we are unable to process incomplete requests. **Controlled medication prescriptions will expire in 21 days.** If the prescription needs to be re-sent to your pharmacy, you will be subject to an additional $5.00 fee. Identification may be requested when picking up paper prescriptions from our office.

We hope that we have answered any questions that you may have about our practice. We are looking forward to assisting you with your medical needs. If you have any questions regarding our office practices and policies, please ask our Clinic Coordinator. If your questions cannot be answered, you will be referred to the appropriate source.

(IN) _______ I understand the policies and procedures listed in this document and request a copy for my records.

(IN) _______ I understand the policies and procedures listed in this document a do not request a copy for my records.

Patient or Responsible Party Signature ____

Printed Name of Patient or Responsible Party ____

Relationship to Patient _______________________________

Today's Date____________________________

Outpatient Medical History

Patient's Name: ______________________________________ **Date of Birth:** _____________________

A. MEDICAL HISTORY (Y= YES, N= NO, U= UNKNOWN)

Has the patient ever been taken to a physician for any of the following?

	Y	N	U			Y	N	U	
1.				Hearing problems	16.				Venereal disease
2.				Vision problems	17.				Measles (what type)
3.				Headaches	18.				Mumps
4.				Head injury	19.				Chicken Pox
5.				Blackouts / fainting	20.				Rheumatic Fever
6.				Seizures / convulsions	21.				Tuberculosis
7.				EEG / Brain wave test	22.				Diphtheria
8.				Diabetes (anyone else in the family/)	23.				Enuresis/Encopresis
9.				Asthma / breathing problems	24.				GI Problems
10.				Serious accident / injury	25.				Repeated infections
11.				Surgery	26.				Urinary
12.				Hallucinations	27.				Cardiovascular
13.				Congenital defects	28.				Respiratory
14.				Suicide gesture / attempt	Date of last pregnancy: (if applicable)				
15.				Female problems / pregnancy					

If "yes" to any of the above, please comment:

____

____

Has the child had previous Psychological/Neuropsychological testing? Yes No

Date of Test: ________________________________ Hours of Testing: ______________

Does the child complain about any pain? (Please describe where and how long.)

____

____

Has the child gained or loss weight? (Please give a brief description.)

____

____

B. Allergies / Type of Reaction:

1. Medications ____
2. Foods ____
3. Other ____

C. Medication History

Is the patient currently on any prescription or non-prescription medication? Please list below:

NAME	DOSAGE	REASON	EFFECTIVE?

Please list any other medication that the patient has taken?

NAME	DOSAGE	REASON	EFFECTIVE?

Did they have any adverse side effects? Yes No

If yes, please explain:

____

____

Date of last physical exam: ______________________

Is the patient currently under a physician's care for any reason? Yes No

If yes, please explain:

____

____

D. DRUGS AND ALCOHOL

Does the patient: Smoke? Yes No How much? ______________________

Drink? Yes No How much? ______________________

Has the patient ever used drugs? Yes No

TYPE	HOW LONG	WHEN

Consent For Treatment

Patient Name: ______________________________________ DOB: ______/______/___________

_____ (INITIALS) I hereby certify that I am the parent/Legal guardian or patient for the above named and that I am authorized to consent for treatment. I hereby authorize *Southwest Psychiatric Physicians* to provide psychiatric treatment that may include prescribing stimulants, antipsychotics, antidepressants, and other classes of medications, for the above-named patient.

Are there any divorce decrees, Power of Attorney, CPS orders, adoption paperwork, etc.?

☐ Yes ☐ No

If yes, a copy of any/all paperwork is **required** to be on file with the office, as this paperwork explicitly describes who has custody of the above-named patient, and what their custodial rights are.

Please list what documents and who else has custody:

____

Is the above-mentioned person aware of this request for treatment? ☐ Yes ☐ No

NOTICE OF PRIVACY PRACTICES/ PATIENT RIGHTS

_____ (INITIALS) I certify that SPP has provided me with a copy of The Notice of Privacy Practices regarding patients' privacy rights; I have reviewed it and understand it.

_____ (INITIALS) I certify that SPP has provided me with a copy of their Policies and Procedures; I have reviewed it and understand it.

Signature of Patient or Parent/Guardian: ____

Printed Name: ____________________________________ Date: ___/___/_____

Relationship to Patient: __________________________

Financial Acknowledgement

I, the undersigned, certify that if I or my dependent has insurance coverage, I am assigning directly to Southwest Psychiatric Physicians all insurance benefits. I understand that I am financially liable for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I also understand that payment of copays, co-insurances, and deductible amounts are due at the time services are rendered.

I acknowledge that if my insurance terminates, I must provide the office with updated insurance information as soon as it is available. If there is a lapse in insurance coverage, my account will be set to self-pay, and I will be financially responsible for any billed amount during the duration of the coverage lapse. If I am a self-pay account at the time of becoming a new patient with the office, I acknowledge that I am financially responsible for all services billed by the provider.

Signature of Patient or Parent/Guardian: ____

Printed Name: _____________________________ Date: ___/___/_____

Relationship to Patient: _____________________

Additional Information Needed

1. A Copy of your unexpired Driver's license is required to be on file.
2. A copy of the front and back of your insurance card is required to be on file.