Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

GENERAL OFFICE POLICIES

Thank you for choosing Dr. Kim Tubbs, DNP for your behavioral healthcare needs. Please read these policies completely and if you have any questions, please ask for clarification.

Appointments: The time of your appointment is reserved for you. You are expected to give at least 24 hours notice if you cannot keep your appointment. **Cancellations within 24 hours will be charged a late cancellation fee of $100.** If you do not cancel your appointment and do not show up for your appointment **you will be billed a no-show fee of $150 that must be paid prior to receiving any further care.** Your insurance company will not cover these fees. Payment is your responsibility. Repeated "no show" or "late cancelled" appointments could result in termination of treatment.

Maintaining Patient Status: It is very important that you be seen on a regular basis. At the end of each appointment we will advise you when to schedule a follow-up appointment. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time. **If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-provider relationship**. We recognize that payments for healthcare can feel burdensome. We will not ask that you return for appointments more often than what is prudently responsible for psychiatric care. However, please keep in mind that we cannot safely and responsibly provide psychiatric care without regular appointments.

Phone Calls: Emergency calls are handled as a priority. If you are experiencing a medical emergency, please call 911 immediately. Routine calls will be handled by our office staff during our normal business hours. Please leave a message on our voicemail and your call will be returned within one business day. Please leave your name, number, and a detailed message. Medication refills, pre-authorizations, and scheduling appointments **are not considered emergencies**.

Email Communications: Once you are an established patient you will be provided with a patient portal. All medical questions should be sent through this portal. Please recognize that this portal is not for emergencies. Please do not send patient specific questions through the general Whole Life Psychiatry website or email as these communications are not confidential.

Divorced/Separated Parent Policy: Please see our Divorced/Separated Parent Policy if this situation pertains to your situation.

Medication Refills: We handle all refills during your regularly scheduled appointments. **If you need to reschedule your appointment, there is a $25 fee for medication refill requests between appointments.**

On the first appointment, prescriptions for 30 days will be given. We cannot give a 90 day prescription on the initial visit.

Patients can be given a 90 day prescription on their subsequent visits if required by their insurance. Patients are expected to keep their scheduled appointments even if they have enough medication. If you cancel or reschedule your appointment because you have a 90 day prescription from a previous visit you will not be given another 90 day prescription in the future.

If you need your medication adjusted or would like to be started on a new medication, we request that you make an appointment. We will not be able to change medications or dosage over the phone.

Our provider requires that you keep scheduled appointments as directed in order to remain current as a patient. Your eligibility for prescription refills is determined by keeping scheduled appointments.

If a controlled substance/narcotic is prescribed to you it is understood that we are the only provider providing this medication to you. If you obtain this medication (or similar medication) from another provider without our knowledge, we will no longer provide prescriptions for this medication and we may be forced to terminate the provider-patient relationship. **Controlled substance prescriptions will only be filled during an appointment.**

We DO NOT respond to pharmacy requests for medication refills. Please be advised that if you are in need of more medication between visits you will need to call the office yourself.

Our office does not refill medications for lost or stolen controlled substance prescriptions. If your prescription or medication is lost or stolen and you have difficulty with withdrawal symptoms you should go to the nearest emergency room.

Prior Authorization for Medications: Your provider prescribes medication based on your condition/illness. Sometimes your insurance company limits the availability or free access to certain medications. At times, they may require two copays. These types of restrictions are between you and your insurance company. You need to contact your insurance company if this issue arises. If they require clinical information from the prescriber, ask them to fax us a written request. You are required to provide them with your medication history, ID numbers, etc**. Please allow us 48-72 hours to get your prior authorization for medication.**

Payment For Services: Payment is due at the time of service. Any past due balance will need to be paid before the next visit. We may need to cancel your appointment if you are unable to pay your balance in full prior to your next visit. We will send two monthly statements and one final collection letter. Any unpaid balance may then be turned over to an outside collection agency. If you are unable to pay your balance in full we can offer you a payment plan with a minimum payment of $100 per month. The complete balance must be paid within six installments (six months). The first payment is due on the day the payment plan is set up. Payments on previous balances are considered separate from your current visit, which will need to be paid at time of service, regardless of any payment plans in place for previous balances.

Credit Card on File Policy: We require your credit or debit card to be kept on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect. Furthermore, an outstanding balance charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

Patients with insurance plans under Obamacare/Affordable Care Act will be required to pay the full visit cost upfront for each visit. We will bill your insurance, and if the insurance pays for the visit and doesn’t ask for a refund/recoupment within 4 months of your visit, we will issue a refund.

By signing below, you agree that you have read and agree with all of our office policies.

____

Printed name of patient

____

Printed name of parent/guardian

____

Signature of patient or parent/guardian

Date: ___/___/___

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Kim D. Tubbs, PHHNP, PA, Inc. is a private psychiatric practice accepting select insurances and cash payments.

Professional Fees:

- Co-payments or balances are due in full at time of service.
- Special financial arrangements must be discussed prior to your appointment.
- Parents/guardians are financially responsible for payment of services provided to minors or other legal dependents.
- Additional fees may include charges for other professional services such as:
  - Third-party report writing.
  - Crisis-related telephone interventions and/or calls after business hours will be charged a $25 "after hour" fee.
  - Consulting with other professionals.
  - Prescriptions outside of an appointment will be assessed a fee of $25 and will only include enough medication to cover the patient until their next appointment.
  - Legal proceedings requiring representation by Dr. Kim Tubbs, DNP will be charged $1000 for the first hour and $300 for each subsequent hour, including preparation time and transportation. All fees must be remitted prior to service.
  - Preparation of records or treatment summaries will be charged $25 for administrative processing.
  - Attorney requests for records will be charged $20/first page and $2/each subsequent page. All fees must be remitted prior to service.
  - FMLA paperwork will be assessed a $125/form fee.
  - Please note: **This office does not complete disability paperwork.**

Payment for Services:

I understand it is my responsibility to know what services are covered by my insurance plan. I have carefully reviewed the section in my insurance coverage that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or are denied by my insurance plan.

I will provide full and accurate insurance information **in advance** of my appointment or will pay for the appointment on a self-pay basis. I will present my insurance card and proper identification at the time of my appointment. **I will provide updated insurance information prior to my appointment in the case of any changes.**

I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party. I understand that, if after 90 days, my insurance company has not responded, I will receive a

statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if insurance payment arrives at a later date.

I authorize Kim D. Tubbs, PMHNP, PA, Inc. to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to Kim D. Tubbs, PMHNP, PA, Inc.

I understand that I am responsible for payment of any balances on my account.

Policy for Missed Appointments and Cancellations:

Appointment times are reserved exclusively for me. To avoid any missed appointments or late cancellation fees, I will call 24 hours in advance to make any changes to my appointment.

I agree that I must give proper notification to cancel an appointment to avoid late cancellation or missed appointment fees. **I agree to call at least 24 hours in advance to cancel or change my appointment.**

Appointment no-shows will be charged a fee of $150. Appointments cancelled within **24 hours** will be charged a fee of $100.

I acknowledge that more than 2 no-shows and more than 3 late cancellations may result in my termination of treatment by Dr. Kim Tubbs, DNP.

BY SIGNING THIS AGREEMENT, I CONFIRM I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY ALL ITEMS AND TERMS SET HEREIN.

____

Printed name of patient

____

Printed name of parent/guardian

____

Signature of patient or parent/guardian

Date: ___/___/___

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

CREDIT CARD ON FILE POLICY

Dr. Kim Tubbs, DNP requires your credit or debit card to be kept on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $25 will be added to your account for any balances that we must attempt to collect. Furthermore, an outstanding balance charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize Kim Tubbs, PMHNP, PA, Inc. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

□Visa □Mastercard □Discover

Credit card number ____

Expiration date_____/________ CVV________

Cardholder name_______________________________________

Cardholder signature____________________________________

Billing address____

City___________________ State______ Zip________________

I, the undersigned, authorize and request Kim Tubbs, PMHNP, PA, Inc. to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Kim Tubbs, DNP.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Dr. Kim Tubbs, DNP in writing and the account must be in good standing.

Responsible party name (print): ____

Responsible party signature: ____

Date: ___ /___ /___

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

CONSENT FOR TREATMENT

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

Date: ___/___/___

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

CONSENT FOR VIRTUAL TREATMENT - TELEMEDICINE

There are potential benefits and risks of video-conferencing (e.g., limits to patient confidentiality, limits to comprehensive evaluations) that differ from in-person sessions. Virtual sessions are offered predominately for those who are sick and unable to attend appointments in-person. The provider may determine that due to certain circumstances virtual appointments are not appropriate and may require in-person appointments.

Confidentiality still applies for telepsychiatry and sessions will not be recorded without permission from all parties.

You agree to use the video-conferencing platform that has been chosen for this practice which is compliant with all laws. You will need a webcam and working microphone for all sessions. If you do not have both you will not be able to participate in virtual appointments. It is important to be in a quiet space free of distractions.

You CANNOT be driving or a passenger in a moving vehicle. The video will not work properly if the vehicle is moving.

It is important to be on time. Please login to the session a few minutes before your assigned time. If you are having issues getting into the session, you may call the office. **We will no longer be calling patients at the time of the virtual appointment**. It is your responsibility to show up in the appointment on time.

If the patient is a minor, an adult parent or guardian must be present for virtual appointments.

It is your responsibility to confirm with your insurance company that telehealth appointments will be covered. If they are not covered, you will be responsible for full payment. You agree to have the credit card on file run for the cost of the virtual appointment. There is a $150 fee for not showing up to your virtual session. There is a $100 fee if you cancel your virtual session with less than a 24 hour notice.

In order to have virtual appointments, adult patients must have an emergency contact on file that we may contact if we deem that you are in an emergency during the virtual appointment.

____
Emergency contact name

____
Emergency contact number

I certify that I have read and fully understand the above statements and consent to virtual/telemedicine appointments.

____
Printed name of patient

____
Signature of patient or parent/guardian

Date: ___/___/___

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

PRESCRIPTION HISTORY CONSENT

Our practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other prescribers have recently prescribed for you. This list is collected from a variety of sources including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your medical record.

I give Dr. Kim Tubbs, DNP permission to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____

Printed name of patient

____

Printed name of parent/guardian

____

Signature of patient or parent/guardian

Date: ___/___/___

Whole Life Psychiatry

Communications Policy

Please provide the email address that you would like to use to receive information regarding the practice, e.g. the office being closed, changes in operations, etc.

Name: *Email:*

Please provide the phone number that you would like to receive appointment reminder calls.

Please be aware that all medical communications, e.g. medication issues, prescription refill requests, physical side effects, or any other medical related question must be sent to Dr. Tubbs through the HIPAA compliant OnPatient Portal. Please do not contact us through the web form on our website, as that is not HIPAA compliant, and will not receive a response. For all medication transfers, please contact your desired end-use pharmacy to initiate the transfer. For any issues with the OnPatient Portal, or any scheduling concerns, please call the office at (972) 812-0517.

Thank you,

Whole Life Psychiatry

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION/MEDICAL RECORDS

Patient name: ____ Date of Birth: _____________________

I hereby authorize Dr. Kim Tubbs, DNP to release/obtain my medical records and any personal health information concerning me to the following people or entities (this may include parents, significant others, other medical providers or therapists):

Name:____

Address:____

Phone: ____

By signing below, I give Dr. Kim Tubbs, DNP consent to release/obtain my medical records/personal health information without any restrictions to/from the above. I understand this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice.

____
Printed name of patient

____
Printed name of parent/guardian

____
Signature of patient or parent/guardian

Date: ___/___/___

Whole Life Psychiatry

Kim D. Tubbs, PMHNP, PA, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information) or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail and text messages).

PATIENT RIGHTS

Access: You have the right to view or obtain copies of your health information with limited exceptions. If you request copies we will charge a reasonable fee to locate and copy your information and postage if you request the copies be mailed to you.

Amendments: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may file a complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

____

Printed name of patient

I, ____, acknowledge that I
(Signature of patient or parent/guardian)

have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, ____, consent to the use and
(Signature of patient or parent/guardian)

disclosure of my personal health information by this office for treatment, billing/payment, and health care operations as outlined in the NOTICE OF PRIVACY PRACTICES.