Prestige Psychiatric Professionals
6619 N Scottsdale Rd, Suite 4
Scottsdale, Arizona, US - 85250

Patient Consents (v1.03)

INFORMED CONSENTS

FULL NAME: *

DATE OF BIRTH: *

CONSENT TO TREAT

1. I hereby voluntarily, apply for treatment from Prestige Psychiatric Professionals, LLC.
2. I understand, I have the right to obtain and will be provided, a paper copy and or electronic copy, signed or not signed, of consent(s), authorization(s) or any other form(s), which I have signed as part of my treatment, furthermore, I understand copies of these forms will not customarily be provided, unless specifically requested.
3. I hereby authorize, the release of medical information necessary to process billing claims. I also authorize payment of medical benefits to Prestige Psychiatric Professionals, LLC, for all services rendered.
4. I understand, before any Drug Enforcement Agency (DEA) Class II/IIN medication(s) will be prescribed; a Controlled Substance Agreement will be required to be signed, otherwise medication(s) which are considered Class II/IIN controlled substance by the DEA may not prescribed, and or patient services may be terminated, at the discretion of the prescribing provider.
5. I understand, a routine database search of the Arizona's Controlled Substance Prescription Monitoring Program (AZCSPMP), will be performed with or without Class II/IIN medications being prescribed.
6. I understand, a photograph will be taken of myself and of a provided picture identification (ID), to verify patient identity.
7. I understand, that I am financially responsible for all charges and or fees, whether they are paid by my insurance company.
8. I understand, that scheduled appointment(s) must be cancelled at least 24 hours in advance, to avoid late cancellation or no-show fees.

MEDICARE AND MEDICAID

Prestige Psychiatric Professionals, LLC does not accept any individual who are actively enrolled and or are receiving services from either Medicare and or Medicaid. Per Federal and Arizona State Law, this includes any individual who would not use their insurance and would want to pay for services rendered by Prestige Psychiatric Professionals, LLC on an out-of-pocket basis. Federal and State Law does not allow any medical provider and or practice enrolled in either Medicare and or Medicaid to accept out-of-pocket payment from any individual who is enrolled and or receiving services from either Medicare and or Medicaid. The individual is required per Federal and State Law to attend a practice and or provider which accepts Medicare and or Medicaid patients.

1. By signing below, you are acknowledging you are not currently enrolled in and or receiving services from Medicare and or Medicaid, this includes the State of Arizona Medicaid program which is the Arizona Health Care Cost Containment System (AHCCCS).
2. By signing below, you are acknowledging it is your responsibility and solely your responsibility to notify Prestige Psychiatric Professionals, LLC prior to attending any or all appointments, if you are enrolled in a Medicare and or Medicaid program.
3. By signing below, you agree to inform Prestige Psychiatric Professionals, LLC if your Medicare and or Medicaid status changes.
4. By signing below, you are acknowledging it is your responsibility and solely your responsibility to notify Prestige Psychiatric Professionals, LLC prior to attending any or all appointments, if your Medicare and or Medicaid status changes.
5. By signing below, you agree not to intentionally or unintentionally withhold, conceal and or manipulate your Medicare and or Medicaid enrollment status from Prestige Psychiatric Professionals, LLC.
6. By signing below, you are releasing Prestige Psychiatric Professionals, LLC from any and all liability, responsibility, and or penalty, civil and or criminally, for you not informing and or updating, Prestige Psychiatric Professionals, LLC of your Medicare and or Medicaid status.

CLINICAL CONDITIONS OF EVALUATION AND TREATMENT

1. My failure to maintain compliance with at least 2 consecutive appointments WITHOUT notification
2. My failure to attend a follow up appointment 90-days post forecasted follow up date
3. Any abuse or misuse of prescribed medication(s)
4. Any usage of any illegal substance under Federal Law
5. Any usage, of any material, for the purpose other than it's intended purpose, which is used to obtain a "high" and/or intoxication
6. Any dangerous or abusive behavior toward PPP staff or other patients
7. My unwillingness to comply with recommended treatment recommendations and/or medication(s)
8. The initiation of involuntary commitment proceedings
9. A break in the therapeutic relationship between the client/patient and the PPP Psychiatric Mental Health provider has occurred
10. Any failure to properly pay for any service which has been provided or will be provided

I understand that in the event of service being terminated (except in cases of involuntary commitment), I may be provided with a 30-day supply of medication(s) and the names of 3 local Psychiatric providers (i.e. referrals) will be provided to me.

TELEMEDICINE INFORMED CONSENT

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Telepsychiatry is a form of telemedicine that allows patients to access psychiatric are using secure videoconferencing technology to virtually connect patients to a remote healthcare provider and/or via telephone communication. Prestige Psychiatric Professionals, LLC is a psychiatric medical group that can provides telepsychiatry to patients.
Expected benefits include: improved access to psychiatric care; increased efficiency in psychiatric evaluation and management; and greater access to psychiatric care.
As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:
• In rare cases, information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate medication decision making by the healthcare professional.
• Delays in medical evaluation and treatment could occur due to deficiencies of equipment.
• Very rarely, security protocols could fail, causing a privacy breach of medication information.

By signing this form, I understand the following:
1. The laws protecting privacy and confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry which identifies you, will be disclosed to researchers or other entities without consent.
2. I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of psychiatric care maybe available to me, and that I may choose one or more of these at any time.
4. I understand that I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

I hereby give my informed consent for the use of telepsychiatry in my medical care by Prestige Psychiatric Professionals, LLC.

FINANCIAL POLICY AGREEMENT

1. Assignment of Benefits. I authorize and instruct my insurance company to reimburse Prestige Psychiatric Professionals, LLC. (Practice) directly for all services rendered. This is a direct assignment of my rights and benefits under my insurance policy. This payment will not exceed my indebtedness to the Practice and I agree to promptly pay the balance of the services rendered.
2. Insurance Benefits. If insurance is excepted, as a courtesy, the Practice or its designated entity, will bill your insurance for all covered services. If my insurance does not pay within 30 days of receipt of a clean claim, the outstanding balance for all services rendered may become the patient's responsibility and will be due immediately.
3. Verification of Benefits. The Practice will attempt to verify my benefits with my insurance company. However, it is my responsibility to understand my plan benefits.
4. Co-Payments. All co-payments must be upfront. The Practice's contract with the insurance company obligates us to collect the co-payments at the time of service. If I am unable to pay my co-payment, the Practice will gladly reschedule your appointment.
5. Deductible. The Practice will not verify if my deductible has been met. If my deductible has not been met, I agree to pay the balance of the deductible at the time of service.
6. Co-Insurance. I understand, if I have a co-insurance portion based on my benefits. I agree to pay my co-insurance balance when services are scheduled.
7. Non-Covered Services. Insurance companies have different coverage benefits. If a service rendered by the Practice is considered a non-covered service by my insurance, I agree to pay for all non-covered services in full at the time of service.
8. Out-of-Network Benefits. If the Practice does not participate or accept my health insurance plan, at the discretion of the Practice, I agree that the Practice may bill my insurance for out-of-network benefits. The Practice is not contractually obligated to accept what my insurance allows and therefore I will be responsible for the remainder of what my insurance does not pay.
9. Self-Pay. If I have no insurance coverage or have no out-of-network benefits, I agree to pay in the total amount for services rendered in full at the time of service.
10. Forms. The completion of various documents and forms are not covered by your insurance. This is the patient's responsibility and is due upon completion. Fees are as follows: FMLA $45, Short Term Disability (STD) Initial $110, STD Extension $75, and Emotional Support Pet Letter $50. All document fees are in addition to the appointment fee. All paperwork is subject to fees and will be on a case by case basis.
11. Secondary Insurance. The Practice does not file claims to secondary insurance, except when they are Medicare cross-over.
12. Late Payment and Collections. If payment for patient due balances is not received on time, a late payment fee of $30.00 will be assessed on my account. If my account is turned over to third-party collection agency due to non-payment, then a collection administrative fee up to fifty percent (50%) of the amount of the outstanding balance will be assessed on my account.
13. Returned Checks. If my check payment is returned for any reason, a returned check charge of $30.00 will be charged to my account. The Practice will then require that all payments be made by cash or credit card.

• The undersigned acknowledges having scheduled a voluntary Psychiatric Mental Health evaluation for diagnostic and treatment purposes with a Prestige Psychiatric Professionals, LLC (PPP) Psychiatric Mental Health provider.
• I acknowledge that I was provided with instructions about the evaluation process, and that the evaluation may include the completion of multiple forms for the collection of clinical information, as well as an interview with a Psychiatric Mental Health provider.
• After completion of the Initial evaluation, I will be provided with the available Diagnostic findings and if I am in agreement, at this point a decision can be made by either party to establish a psychiatric provider-patient relationship or not. In the event of either

myself refusing to continue with services with PPP or PPP decides not to be my Psychiatric Mental Health provider, I will be provided with the name of at least 3 local Psychiatric providers capable of providing me with a second opinion.

• I acknowledge that PPP will not provide me or my family with formal Psychotherapy services beyond supportive therapy in the context of medication management and Psychiatric evaluation. If PPP recommends formal Psychotherapy services, it is my sole responsibility to procure and secure those services.

• I acknowledge that the completion of Disability, Family and Medical Leave Act (FMLA), School, employment and/or other forms; is beyond the scope of the provider's medication management practice and not considered as part of the evaluation and management reimbursement fee, and will be charged a separate fee, based on the time and complexity of the form.

• I understand that my medication management visits are scheduled for 15-20 minutes. If I arrive 10 minutes late to my appointment based on the office time, I will be considered as having missed my appointment and will be rescheduled for the next available appointment. I also agree that if I don't cancel my appointment at least 24 hours in advance, a fee of $100 will be charged to my account. I understand that occasionally, the PPP Psychiatric Mental Health provider may run late on his schedule due to unexpected patient situations.

• I acknowledge that Prestige Psychiatric Professionals, LLC, DOES NOT provide Emergency Psychiatric or Continuous Crisis Management Services and I agree to call 911 or visit the closest Emergency Room or Psychiatric Urgent Care/Hospital in the event of a Psychiatric Emergency.

• I understand that PPP schedule is filled in advance and does not allow for a patient to be seen on an urgent basis or as a walk-in, unless there is a cancellation and that any questions regarding medication(s) or treatment should be directed to the prescribing PPP Psychiatric Mental Health provider.

• I also acknowledge that PPP, will ONLY provide Emergency Medication bridges on a case by case basis, which typically is only for distinct circumstances; there is an associated fee of $35 for the Emergency Medication bridge. When an Emergency Medication bridge is provided, it will be for a maximum of 7-14 days. An after-hours Emergency Medication bridge will have an associated fee of $50 in addition to the after-hours call fee.

• It is my responsibility to assure that an adequate supply of medication(s) is always maintained, that appointments are made and attended at least 7-10 days prior to running out of my most recent medication prescription(s).

• Prestige Psychiatric Professionals, LLC policy is to write prescription(s) for no longer then 30-days for Scheduled II Substance(s), except for case-by-case extenuating circumstances, with the knowledge this practice will not become a routine practice.

• Not including, Scheduled II Substance(s), Prestige Psychiatric Professionals, LLC policy is to write prescription(s) for no longer then 90-days, except for case-by-case situations.

• I am aware and agree to the following; if, I have not attended, a follow up appointment within 90-days post my previous forecasted follow up appointment date, my patient status will be changed to "Inactive" and in order to restart Psychiatric treatment with Prestige Psychiatric Professionals, LLC, I will require an Initial Appointment.

• I am aware and agree that Prestige Psychiatric Professionals, LLC will terminate my clinical services upon my verbal or written request. I am aware and agree that Prestige Psychiatric Professionals, LLC may terminate my clinical services due to any of the following:

14. No Show and Late Cancellations. If a patient does not show for a scheduled appointment without prior notice or is a “No Show” and/or a patient does not provide 24-hour notice prior to their scheduled appointment; the patient will be charged the following fee:

a) NEW PATIENT NO SHOW = $100

b) NEW PATIENT LATE CANCELLATION = $100

c) ESTABLISHED PATIENT NO SHOW = $100

d) ESTABLISHED PATIENT LATE CANCELLATION = $100

These fees are my responsibility and cannot be billed to my insurance. At the discretion of the Practice; all fees must be paid prior to another appointment being scheduled.

15. Collection Agency and Attorney Fees. If your account becomes delinquent and is referred to a collection agency or attorney for collection, I will be responsible for any administrative, collection, or attorney fees up to 50% of any outstanding balance.

16. Direct Payment. Direct payment for your health care services. The Arizona Constitution permits you to pay a health care provider directly for health care services. Before you make any agreement to do so, please read the following important information:

If you are an enrollee of a health care system (more commonly referred to as a health insurance plan) and your health care provider is contracted with the health insurance plan, the following apply:

1. You may not be required to pay the health care provider directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.
2. Your provider's agreement with the health insurance plan may prevent the health care provider from billing you for the difference between the provider's billed charges and the amount allowed by your health insurance plan for covered services.
3. If you pay directly for a health care service, your health care provider will not be responsible for submitting claim documentation to your health insurance plan for that claim. Before paying your claim, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.
4. If you do not pay directly for a health care service, your health care provider may be responsible for submitting claim documentation to your health insurance plan for the health care service.

Upon request, the following will be provided to you, upon completion of each appointment, a receipt that includes the following information:

1. The amount of the direct payment.
2. The applicable procedure and diagnosis codes for the services rendered.
3. A clear notation that the services were subject to direct payment under this section.

17. Fee Structure. The following is the Practice's primary service fee structure;

a) Initial Psychiatric Assessment with or without medication management, fee of two hundred ninety dollars ($290) per 45-90 minute appointment, this includes either a face-to-face appointment or via telemedicine.

b) Follow-Up Psychiatric Assessment with or without medication management, fee of one hundred fifty dollars ($150) per 15-25 minute appointment, this includes either a face-to-face appointment or via telemedicine (video conference or telephone).

c) Concierge Psychiatric Assessment with or without medication management, fee of five hundred dollars ($500) per appointment, this includes a face-to-face appointment at the patient's residence.

d) Any patient care-oriented telephone call and or text message, not initiated by the Practice, other than provider to provider, has a thirty-five dollar ($35) associated fee.

e) Any off-hour (7pm to 8am and on weekends) patient care-oriented telephone call, electronic mail (e-mail) and or text message, not initiated by the Practice, has a seventy dollar ($70) associated fee.

f) Any Emergency medication bridge, has a thirty-five dollar ($35) associated fee and will be provided for a maximum of 7-14 days as deemed appropriate by the prescribing provider.

g) Any off-hour Emergency medication bridge (from 7pm to 8am and on weekends), has a fifty dollar ($50) associated fee.

h) Family and Medical Leave Act (FMLA) paperwork, has a forty-five dollar ($45) associated fee.

i) Short-Term Disability (STD) Initial paperwork, has a one hundred ten dollar ($110) associated fee.

j) Short-Term Disability Extension paperwork, has a seventy-five dollar ($75) associated fee.

k) Emotional Support Pet Letter, has a fifty dollar ($50) associated fee, per pet.

l) Medication Prior Authorization paperwork, has a twenty-five dollar ($25) associated fee per medication.

m) Late payment for provided service, has a thirty dollar ($30) associated fee per incident.

n) Hiring of third-party Collection Agency and/or Attorney, has a fee of up to fifty percent (50%) of outstanding balance due.

o) Returned Check, has a thirty dollar ($30) associated fee.

p) Any request by the patient and or their representative to send a prescription to a different pharmacy after the prescription has already been sent to a pharmacy, has a twenty-five dollar ($25) associated fee, per medication.

q) Any request by the patient and or their representative to change the patient's scheduled appointment time on the day of their appointment, to another time and or date, has a twenty-five dollar ($25) associated fee.

A sliding fee structure can be utilized based on the necessity of the patient and agreed upon by the patient and the Practice. All fees are non-negotiable; however, fee collection is solely at the discretion of the Practice to pursue collection of associated fees.

Your signature below acknowledges you received, or reviewed and or signed, this notice before paying directly for a health care service.

Your signature below acknowledges your right to receive a copy of this form, upon request.

Prestige Psychiatric Professionals
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Your signature below acknowledges you have read the following sections of this form.

• CONSENT TO TREATMENT

• MEDICARE AND MEDICAID

• CLINICAL CONDITIONS OF EVALUATION AND TREATMENT

• TELEMEDICINE INFORMED CONSENT

• FINANCIAL POLICY AGREEMENT

Furthermore, my signature below demonstrates I have read and understand the information provided above regarding treatment, conditions of evaluation and treatment, telepsychiatry, and the terms of the financial policy agreement. I have discussed it with my mental health provider or designated assistant, and all my questions have been satisfactorily answered.

Terms are subject to change without prior notification.

Date: *

PATIENT SIGNATURE: *