Solace Psychiatry at Riverstone

Adolescent, Adult Psychiatry & Interventional Psychiatry
(rTMS, Ketamine Infusion Therapy)
4502 Riverstone Boulevard, Suite 601, Missouri City, TX. 77459; Ph 281.778.9530

PATIENT INFORMATION

This office uses an electronic health record. Please complete the information below so we can communicate with you according to our necessity and your preferences.

Demographic and Clinical Information

Name:_____Date:_____SSN:_____
Street Address: _____DOB:_____
City: _____ State: _____Zip Code:_____

Employer:_____Occupation: _____

Marital Status: ❑ single ❑married ❑ domestic partnership ❑separated ❑divorced ❑widowed

Spouse/Partner Name: _____ Spouse/Partner Phone: _____

Telephone Communications

Please only leave phone numbers where you are willing to accept an incoming call from our office.

Cell Phone:_____
May we leave messages on your VM? ❑Yes ❑ No

Home Phone:_____
May we leave messages on your VM? ❑Yes ❑ No

Work Phone:_____
May we leave messages on your VM? ❑Yes ❑ No

Electronic Communications

Please only provide your email address if you consent to email communications with Solace Psychiatry At Riverstone.

Email address (print carefully):_____

- Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.
- No one can diagnose your condition from email or other written communications, and communication via these means cannot replace the relationship you have with your clinician.
- Emails are checked during business hours only. If you have a matter that requires urgent attention after hours or on weekends, please do not leave an e-mail. Dial 9-1-1 or go to the nearest emergency center.
- Communications via email or text are not encrypted but are still considered part of your health record.
- Any text or email initiated by yourself is an implicit consent to receive electronic communications from our office within the same medium (i.e. sending an email to Solace Psychiatry At Riverstone's email account or a clinician implies agreement to receive a reply via email).

Missed Appointments and Late Cancellations

It is your responsibility to notify Solace Psychiatry At Riverstone 24 hours or greater prior to your scheduled appointment.

- I hereby agree that I will be fined $65 for missed appointments. This is a non-covered fee and cannot be billed to your insurance.
- Any appointment cancelled on the same day will be billed $50. This is a non-covered fee and cannot be billed to your insurance.
  In the event of an emergency, please inform our office of the circumstances for your absence and an exception to the fine may be considered according to the discretion of management.
- Showing up late (more than 10 minutes) for an appointment may result in cancellation

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Source of Payment – Insurance, Co-Pays, Cash

❑I will pay cash (we accept cash or credit) for my visit

❑I will pay any co-pays/deductibles due; I would like Solace Psychiatry at Riverstone to file with insurance on my behalf. I understand that ultimately, I am responsible for payment and if payment is not received from my insurance company within 120 days, I will be billed directly.

Primacy Insurance Company:_____Policy ID #_____ Group #_____

Insurance Address:_____Insurance Phone #:_____

Policy Holder's Name:_____Policy Holder's Birthdate:_____

Signature of Guarantor:_____Policy Holder SSN: _____

Guarantor Name:_____Relationship to Patient: _____

If different from patient information above:

Address:_____Zip: _____

Cell No: (_____)_____ Business No: (_____)_____

Secondary Insurance Company:_____Policy ID #_____ Group #_____

Emergency Communications

Emergency Contact:_____Relationship: _____

Emergency Contact Phone: (_____)_____

Preferred Pharmacy Information

Pharmacy Name: _____

Address:_____Zip: _____

Phone: (_____)_____ Fax: (_____)_____

POLICIES AND PROCEDURES FOR Solace Psychiatry at Riverstone

Privacy, Disclosure, Confidentiality and Release of Information _____ (initials)

Our practice values and upholds the importance of your confidentiality. In addition to your rights as a patient, our duty is to protect your confidential information and inform you of changes. We are required by law to maintain the privacy of confidential information and provide you with notice of our legal duties and privacy practices with respect to such information. We are required to abide by the terms of this notice currently in effect. Your rights and our responsibilities are summarized below. There are however, certain situations in which we must, by law, communicate your confidential information. Here is list of those circumstances:

- We have reason to believe you are a danger to yourself or another person or persons
- We become aware of abuse to children, the elderly or developmentally disabled persons
- We are under court order to release information
- Subpoena of treatment records by an attorney (We will not immediately release records upon receipt of a subpoena but will do everything in our power to keep your records private. Usually a court order will be required. You have up to fourteen (14) days to obtain a protective order from the court to avoid disclosure of your records)
- If you are party to a child custody litigation at any time in the future, the court may order release of information about your treatment.
- Please see our complete Notice of Privacy Policy for more information.

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents, as well as business associates of the practice. The following routine situations necessitate the use of your information:

- For Treatment - We may use information about you in order to provide you with proper medical treatment or services. An example of treatment is when we consult with another healthcare provider, such as your primary care provider or order labs or imaging studies. HIPAA generally does not limit disclosures of PHI between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes.
- For Payment - We may use and disclose information about you so that the treatment and services you receive can be collected from an insurance company. We may also tell your health insurance plan about a treatment you are going to receive, in order to obtain precertificiation or determine if your plan will cover the treatment.
- For Healthcare Operations - We may use and share information about you for administrative functions necessary to run the practice and promote quality care. We may share information with business associates who provide services necessary to run the practice, such as billing services.

The following special circumstances necessitate the use of your information:

Communicating with You and Others Involved in Your Care _____ (initials)

This practice may contact you via telephone and leave a message on your voicemail or with the person answering your phone to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may also send you a text reminder to your mobile phone for your appointment. In emergencies or other situations in which you are unable to indicate your preference, we may need to share information about you with other individuals to coordinate your care or notify your family.

Payment_____ (initials)

We accept cash, checks, debit or credit card for your appointments. We also will file insurance on your behalf if you wish. Prior to your first appointment, we will obtain relevant insurance information which will allow us to verify your

insurance coverage as well as to identify what your out-of-pocket responsibility will be for mental health services. However, you (and not your insurance company) are responsible for the payment of our fees.

If you have a co-payment, deductible, fees or any balance due it will be collected at the beginning of each session. We accept cash, check, debit or credit card. We will bill your insurance company on your behalf. We will assist you in any way we reasonably can to help you get your claims paid. However, if your insurance company does not pay your claim within 120 days after date of service, the balance will automatically be billed to you.

If you do not have one of the insurances we are credentialed with, payment in full is due at each visit. We will provide a receipt which you may submit to your insurance company to request reimbursement for services from an out-of-network provider.

In the event that your insurance coverage changes, it is your responsibility to inform the clinic prior to your appointment about any changes to your insurance

Non-payment – if your account is over 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Please be aware that if your balance remains unpaid, we will refer your account to a collection agency and you will be discharged from our practice.

Video Recording Policies _____ (initials)

I understand that Solace Psychiatry at Riverstone makes limited use of video surveillance systems for the safety and security of our patients and clinicians. A security officer will view camera on a periodic basis. I understand that only the Solace Psychiatry at Riverstone will have access to the monitoring.

Professional Fees _____ (initials)

- Initial psychiatric evaluation and management: $350/ Follow-up psychiatric evaluation & management $185
- Psycho Social Assessment $200 / Therapy follow Up $150
- Video consultation (telepsychiatry) Initial $ 350 Follow-up $185
- Completion of forms (such as FMLA) & Disability $75-$150
- Letters to universities, employers, etc. $30
- NSF Fee $50/ Check cancel fee $50
- Telephone calls with providers $30 for > 10 minutes
- No Show Fee $65
- Same day appointment cancellations. $50
- Saturday Convenience Fee $25

Medication Refill Policies _____ (initials)

- <u>It is your responsibility to notify the office in a timely manner when refills are necessary. Please keep track of when your medication are about to run out, and notify us with 2 business days' notice.</u>
- Approval of your refill may take up to three business days so please be courteous and do not wait to call.
- If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due.
- Medication refills will only be addressed during regular office hours (Monday-Friday 8am-5pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.
- We do not replace lost, stolen, misplaced, or otherwise unavailable medication early except under very special circumstances; if an exception is made, it will be only once.
- It is important to keep your scheduled appointment to ensure that you receive timely refills.
- If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please schedule an appointment.
- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Litigation Policy and Fees for Court-Related Services _____ (initials)

It is important to our practice that we be accessible to as many patients as possible throughout the day. For this reason, we want to avoid at all costs, being involved in any legal commitments, such as litigation, subpoenas, depositions, etc. on behalf of an individual patient's legal disputes. Legal commitments such as these take our providers away from the practice, and in essence away from patient care. If in any case you are to become involved in any legal proceeding during your care with our providers, including but not limited to divorce and custody disputes, or personal injury lawsuits, you agree that neither you, nor your attorneys, nor anyone acting on your behalf will subpoena records from our office, or subpoena our clinicians to testify in court, in a deposition or in any legal proceeding. If we are to be involved in your litigation, or if you or your attorneys subpoena our providers or staff to provide medical records, testify in court or give a deposition in violation of this agreement, we will have no choice but to comply. For this, our providers will require compensation.
The hourly charge for all time related to court cases or litigation is $500 per hour. You will be asked to sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time we must spend dealing with your litigation, and by your signature below, you agree not to contest any fees that are charged to your credit card as a result of this Agreement, and specifically, this section of the Agreement. If we are subpoenaed to provide records or testimony in violation of this agreement you acknowledge and agree that you will be billed for the provider's professional time including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition regardless of which party issues the subpoena or requires us to testify. If we are required to testify in court or give a deposition in Fort Bend County, we will charge a retainer in the amount of $2,000 (a minimum of 4 hours at $500 per hour), which includes preparation time, travel time (door-to-door), and attendance at any legal proceeding. If we are required to testify in court or give a deposition outside of Fort Bend County, the retainer will be $3,000 (a minimum of 6 hours at $500 per hour). If the testimony or deposition exceeds the retainer for 4 hours (in Fort Bend County) or the retainer for 6 hours (outside Fort Bend County), we will bill each additional hour spent attending a court hearing or deposition and we will charge your credit card for the balance. In order to go to court or give a deposition, providers need to reschedule their appointments to clear their day, therefore there is a 48-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for Monday, this office must be notified of any cancellation no later than Noon on the Thursday before. Any cancellations that occur within the 48-hour time frame of the court appearance or deposition are NONREFUNDABLE. We will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. All payments are due 48 hours prior to the scheduled court appearance or deposition, and no later than 12:00 Noon on Thursday if the court hearing/deposition is scheduled for a Monday. By your signature below, you expressly authorize us to run these charges to the credit card on file in our office unless you notify our office that you intend to make payment by cash, money order or cashier's check.

We will not perform forensic psychiatry or custody evaluations. We will not conduct assessments for FMLA, short-term or long-term disability applications. We will not provide recommendations regarding possession, custody, access to or visitation with minor children.

Right to Terminate Treatment_____ (initials)

In certain rare circumstances, our clinic may reserve the right to terminate your treatment. We will immediately notify you if this occurs, and will allow you a 30-day period to find a different provider. We will do our best to recommend further referrals.

In the event of misuse of prescriptions or in the case that your treatment is no longer seen as therapeutic, such that our options are maximized and further rapport and agreement in your care is compromised, then we may terminate our professional relationship.

We also reserve the right to terminate your privileges as patient in the event of repeat nonpayment. We will do our best to accommodate any financial difficulties through payment plans if concerns are discussed with us.

We also reserve the right to terminate treatment with repeat missed appointments.

In addition, we reserve the right to terminate a professional relationship when a patient exhibits violent (verbal or physical) behavior (i.e. shouting, use of profanity, use of intimidation). We have a no tolerance policy for patients who show aggression in any way.

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Consent for Treatment _____ (initials)

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by clinical professionals at Solace Psychiatry at Riverstone. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

For minor children (< age 18) with divorced parents, we will require a copy of the Divorce Decree or Court Order prior to providing any services. By your signature below, you are indicating that you have the legal right to consent to psychiatric or psychological care on behalf of your child.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Parent, Legal Guardian or Conservator Date Signed

Please notify us if: _____ (initials)

1. Notify your clinician if there are any significant changes in your psychiatric or medical condition.
2. Notify your clinician if you suspect or know that you are pregnant or if you plan to become pregnant in the near future. Pregnancy will affect treatment recommendations.
3. If you feel you are at any risk for hurting yourself or others, call 911 or go to nearest emergency center.
4. If your medication makes you drowsy or slows your reaction time, refrain from driving.
5. Notify your clinician if your medication causes you other significant side effects.
6. If you want to increase, decrease, or discontinue your medication regimen, call first. Medication management is a collaborative process. Changes without consultation are potentially dangerous and may interfere with our ability to work together.
7. It is advised not to drink alcohol while taking psychiatric medications.

Telepsychiatry Informed Consent_____ (initials)

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist or psychiatric clinician and the patient are not in the same physical location. Solace Psychiatry At Riverstone allows its clinicians to perform telepsychiatry, but only through the telemedicine service provider Doxy.me, LLC. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Telepsychiatry Benefits:
- Increased accessibility to psychiatric care.
- Patient convenience.

Potential Telepsychiatry Risks:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by my psychiatrist.
- Delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If I decide that the benefits outweigh the risks, I may request telepsychiatry sessions when I schedule follow-up appointments. If my psychiatric clinician agrees, I will be scheduled for a telepsychiatry session, and I will be contacted for payment and sent an internet link (to http://Doxy.me) with instructions to log into the "waiting room" immediately prior to my scheduled appointment.

My Rights:
(1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry.
(2) I understand that all the Texas rules and regulations which apply to psychiatry also apply to telepsychiatry.
(3) I understand that my psychiatric clinician has the right to withhold or withdraw his /her consent for the use of telepsychiatry at any time during the course of my care.
(4) I understand that I have the right to withhold or withdraw my consent for the use of telepsychiatry at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment.

My Responsibilities:
(1) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have working camera and audio input.
(2) I will not record any telepsychiatry sessions without written consent from The Solace Center for Psychiatry, and I understand that my psychiatric clinician will not record any of our telepsychiatry sessions without my written consent.
(3) I will inform my psychiatric clinician if any other person can hear or see any part of our session.
(4) If I lose my connection during a session, I will immediately attempt to log back into the http://Doxy.me "waiting room".
(5) If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my clinician know to schedule a new appointment.

Patient Consent to the Use of Telepsychiatry
I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent Patient Consent to the Use of Telepsychiatry I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize my psychiatric clinician to use telemedicine in the course of my diagnosis and treatment. I agree to hold Solace Psychiatry at Riverstone and its clinicians harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

_____ _____
Printed name _____

_____
Signature of patient (or parent, legal guardian, or conservator) (Relationship to patient)