

## Patient Agreement

### ***Welcome to Community Psychiatry***

Community Psychiatry's dedicated providers and staff are committed to ensuring that each and every patient receives the highest quality psychiatry services possible. This Patient Agreement establishes guidelines for your participation in treatment with us. Please read the entire Agreement and ask front desk staff if you have any questions.

### ***Initial Evaluations***

***Children.*** Initial evaluations for children involve two 45-60 minute sessions. The purpose of these sessions is to obtain a detailed history and perform a comprehensive examination. Your child's provider may request information from your child's other health care providers and school before making a definitive diagnosis and/or treatment recommendations.

***Adults.*** Initial evaluations for adults involve one 45-60 minute session. Your provider may request information from your other health care providers before making a definitive diagnosis and/or treatment recommendations.

### ***Follow-Up Sessions***

Following the initial evaluation, your (or your child's) provider will discuss his/her assessment with you and make recommendations regarding medication(s) and/or psychotherapy. Your provider may request a blood test or an EKG prior to starting you on a particular medication. If your provider determines medication is appropriate for your treatment, our staff will schedule you for follow-up sessions every one to two weeks during the initial phase of treatment. In these sessions your provider will carefully monitor your (or your child's) reaction to the medication(s) prescribed and any side effects. These follow-up sessions typically last 20-30 minutes, although they may take somewhat longer in the early stages of treatment.

### ***Regular Attendance***

The relationship between a provider and his/her patient is a partnership and regular attendance at appointments is a critical part of your care. Although regularly scheduled visits with your provider may at times feel burdensome, this commitment helps ensure that you receive the highest quality care possible.

### ***Late Arrivals***

If you arrive late for a scheduled appointment and your provider determines that there is enough time remaining, he/she will see you for the remainder of your appointment time. That said, your provider may also request that you schedule an additional appointment with him/her.

### ***No Show & Late Cancellation Policy\****

We reserve your appointment time specifically for you and you alone. For this reason, Community Psychiatry charges a \$50 fee for no shows and appointments cancelled with less than two (2) business days' notice. Please also be advised that after you no show to or late cancel three (3) scheduled appointments, your provider may terminate his/her relationship with you for non-compliance. We also understand that your time and money is valuable. For this reason, our office staff will call or text you to remind you of scheduled appointments.

*\*Pursuant to California law, Medi-Cal patients are not charged no show/late cancellation fees.*

### ***Children and Appointments***

We kindly ask that you do not bring your children to your appointments unless they are also being seen at Community Psychiatry, or are specifically requested to attend by your provider. Please note that we do not permit children in our waiting area without the supervision of a parent, guardian, or caretaker.

### ***Same Day Appointments***

Many insurance companies do not pay for two mental health visits on the same day. If you have visits with your psychiatrist and therapist on the same day, you may have to pay out-of-pocket for one of these visits.

### ***Gastric Bypass Evaluation***

If you are seeking a psychiatric evaluation for gastric bypass surgery, the cost of the evaluation may not be covered by your insurance plan. Please check with our front office staff to confirm the cost of your visit.

### ***Emergencies and Urgent Consultations***

For your benefit, a covering provider will be available each day after office hours until 9 p.m. to assist you with any urgent issues or problems you are having with medications. To reach the covering provider, please call us at (855) 427-2778 and listen for our covering provider's phone number. In the event of an emergency, please call 911 or go directly to the emergency room.

### ***Forms and Documents***

As necessary, medical forms will be completed by your provider while he/she meets with you in your session. Please notify your provider at the beginning of each session if you need certain forms completed.

### ***Requests for Disability***

Community Psychiatry does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you your provider may be willing to complete short-term disability paperwork on your behalf, however your provider is not required to do so and may decline to assist with such a request. Your provider may also require you to schedule a separate follow-up appointment with him/her for this purpose.

### ***Medications***

Our providers typically evaluate adults for one session and children for two sessions before determining whether medication is indicated for care. For child patients, the decision to start a medication often cannot be made during the first session and is usually deferred until the child's second session to allow the provider adequate time to obtain a full history and review any requested medical or school records.

To ensure the best reaction to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment please call our office one week prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, cancelled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication. In general, we will insist that you see your provider before refilling your medication.

**NOTICE TO CONSUMERS**  
**Medical doctors are licensed and regulated by the Medical Board of California**  
**(800) 633-2322 [www.mbc.ca.gov](http://www.mbc.ca.gov)**

I have read and agree to this Patient Agreement in its entirety.

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Patient Signature

Date

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Patient Name

If you are signing this Patient Agreement as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Parent   | <input type="checkbox"/> Conservator           | <input type="checkbox"/> Power of Attorney for Health Care |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Health Care Surrogate | <input type="checkbox"/> Executor/Administrator            |

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Signature

Date

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Name

## Consent to Treatment

I am voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Community Psychiatry for the purpose of diagnosis and treatment, and I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that Community Psychiatry's providers include psychiatrists and psychiatric mental health nurse practitioners. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I understand that if the patient is a minor under the age of 12 and I am consenting to treatment on the minor's behalf, I must indicate my authority and sign below. I also understand that if I share legal custody of the minor patient, by signing this consent form I am representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

I understand that if I am a minor between 12 and 17 years of age, I have the right to alone consent to outpatient mental health treatment with Community Psychiatry and therefore must sign this consent form in order to be treated by Community Psychiatry. However, if I require prescription medication for my treatment, my parent or guardian is required to sign a separate Consent to Medications form consenting to such prescriptions.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent to treatment at any time.

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Patient Signature

Date

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Patient Name

If you are signing this Consent for Treatment as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

Parent                       Conservator                       Power of Attorney for Health Care

Guardian                       Health Care Surrogate                       Executor/Administrator

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Signature

Date

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Name

## Acknowledgement of Financial Responsibility & Credit Card Authorization

I hereby assign payment of my insurance benefits to Community Psychiatry and authorize Community Psychiatry to disclose my health information to my insurance company in order to obtain payment for services rendered to me. I understand that I am financially responsible for all charges not covered by my insurance plan, including copays and deductibles and no show and late cancellation fees incurred by me, which are due at the time of my visit.

I authorize Community Psychiatry to keep my credit card information below on file and charge my credit card for amounts owed by me. I understand that I will be sent receipts for credit card charges via mail or e-mail and that such charges will appear on my credit card statement.

### **Balance under \$100**

I understand that Community Psychiatry requires me to keep a balance of under \$100 in order to continue to be seen by my provider and that if I fail to do so, I may be terminated by my provider for non-payment.

### **Insurance and Credit Card Information**

I understand that I am responsible for providing Community Psychiatry with accurate and complete insurance information. I also understand that I am required to notify Community Psychiatry of any changes in my insurance coverage or credit card information and will be personally responsible for the cost of my care if I provide inaccurate or incomplete insurance information to Community Psychiatry or my coverage or credit card lapses.

### **Medi-Cal Patients**

I understand that if I have a Medi-Cal plan I am only financially responsible for copay and share of cost amounts.

### **Payment for Minor Patient**

I understand that the adult accompanying a minor to his/her appointment is responsible for payment for services. If a minor is unaccompanied by an adult to his/her appointment, and did not alone consent to treatment, the minor's parent/guardian is responsible for sending the minor's copayment with him/her.

### **Payment by Check**

I understand that after issuing Community Psychiatry two (2) checks that are unable to be processed for insufficient funds, Community Psychiatry will no longer accept checks as a form of payment from me and I will be charged for any fees assessed Community Psychiatry for such invalid checks.

### **Past Due Balance**

I understand that if I have a past due balance, I may establish a payment plan with Community Psychiatry, with which I must comply in order to continue to be seen by my provider.

I understand that this Acknowledgement of Financial Responsibility & Credit Card Authorization will remain in effect until I provide written notice of cancellation to Community Psychiatry.

|  |                                     |   |
|--|-------------------------------------|---|
| Patient Name                                   | Patient/Responsible Party Signature | Date                                      |
| Cardholder Name                                | Card Holder Signature               |   |
| <input type="checkbox"/> Visa                  | <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover         |
|  |                                     | <input type="checkbox"/> American Express |
|  |                                     | <input type="checkbox"/> Other            |
| Credit Card Number                             | Expiration Date                     | Security Code                             |
| Cardholder Address (Street, City, State, Zip ) |                                     |   |

## Consent to Obtain Medication History

Community Psychiatry uses a program called OnCallData to enable providers to electronically prescribe medications to patients. Using OnCallData, providers transmit prescriptions to a patient's desired pharmacy electronically from the point-of-care. OnCallData also allows providers to obtain a patient's prescription medication history upon his/her consent. This information helps providers to identify potential medication issues, such as drug interactions and duplicate prescriptions.

I hereby authorize Community Psychiatry to request and use my prescription medication history collected from other healthcare providers, third-party payers (i.e., my insurance company) and pharmacies for treatment purposes.

I understand that this Consent to Obtain Medication History will remain in effect until I provide written notice of cancellation to Community Psychiatry.

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Patient Signature

Date

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Patient Name

If you are signing this Consent to Obtain Medication History as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- |                                   |  |  |
|-----------------------------------|--|--|
| <input type="checkbox"/> Parent   | <input type="checkbox"/> Conservator           | <input type="checkbox"/> Power of Attorney for Health Care |
| <input type="checkbox"/> Guardian | <input type="checkbox"/> Health Care Surrogate | <input type="checkbox"/> Executor/Administrator            |

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Signature

Date

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Name

## E-Mail Authorization

I hereby request that Community Psychiatry and my provider, \_\_\_\_\_, communicate with me regarding my treatment via electronic mail, or e-mail.

I understand that this means Community Psychiatry staff and my provider will transmit my protected health information, such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment, via e-mail. I understand there are risks inherent in the electronic transmission of information by e-mail, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered. I further understand that any protected health information transmitted via e-mail pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, neither Community Psychiatry nor my provider shall have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the e-mail of information by Community Psychiatry or my provider to me.

After being provided notice of the risks inherent in use of e-mail to transmit protected health information, I hereby expressly authorize Community Psychiatry and my provider to communicate via e-mail with me, which will include the electronic transmission of my protected health information. I understand that this E-mail Authorization will remain in effect until I revoke it by submitting notice to Community Psychiatry in writing.

I hereby authorize the transmission of my protected health information via e-mail as described above.

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Patient Signature

Date

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Patient Name

