**PATIENT INTAKE FORMS, INTRODUCTION**

Dear Patient,

Welcome to Integrative Psychiatry Services (IPS). We are honored to serve you. Enclosed is a packet of forms that require your signature before your appointment.

You might notice that our forms are extensive. Indeed, it is our attention to detail that distinguishes us from other practices. Your evaluation and explanation of treatment options will be equally thorough.

At the end of this packet is a handbook. This handbook is your guide on how to communicate with us between appointments. Please read it carefully while you wait for your provider to come get you, and ask us any questions as they arise!

We look forward to working with you. ☺

Lila Massoumi, MD

*This section for receptionist use only*

|  |  |  |
| --- | --- | --- |
|  | **FORM SIGNED?** | |
| **NAME OF FORM** | **YES** | **NO** |
| Face Sheet & Demographics |  |  |
| HIPAA |  |  |
| Consent for Assessment, Tx, and Arbitration |  |  |
| ROI |  |  |
| Fee Schedule Agreement for all patients |  |  |
| CC auth agreement |  |  |
| BCBS / Priority Health agreement |  |  |
| MDCD agreement for all patients |  |  |
| MDCR agreement for all patients |  |  |
| Controlled med refill policy |  |  |
| Electronic / Txt communications |  |  |

Name, Signature, and Date of Notary Public: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | |
| First Name: | | Last Name: | | | | | | | | | |
| Street Address: | | | | | | | | | | Apartment Number: | |
| City: | | | | | | State: | | | Zip Code: | | |
| Date of Birth: | | | | Gender:   * ☐ Male * ☐ Female * ☐ Transgender Male/Transman/FTM * ☐ Transgender Female/Transwoman/MTF * ☐ Gender-queer * ☐ Additional category (please specify): \_\_\_\_\_\_\_\_\_\_\_ * ☐ Decline to answer | | | | | | | Sex Assigned at Birth:   * ☐ Male * ☐ Female * ☐ Decline to answer |
| Age: | | | |
| Marital Status:  ☐Single  ☐Married/Partnered  ☐ Other (please specify): \_\_\_\_\_\_ | | | |
| Employment Status:  [ ] Employed [ ] Unemployed | Company: | | | | Position: | | | | | | |
| Daytime Phone #:  Is it ok to leave a voicemail at this #? **Circle one:** *Yes* or *No* | | | Evening Phone #:  Is it ok to leave a voicemail at this #? **Circle one:** *Yes* or *No* | | | | | Cell Phone #:  Is it ok to leave a voicemail at this #? **Circle one:** *Yes* or *No* | | | |
| Which phone number do you prefer we contact? : | | | | | | | Referred by: | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE INFORMATION** | | | |
| Name of Insurance: | | Subscriber’s name (if different than patient): | |
| Enrollee ID: | Group Number: | | Subscriber DOB: |

|  |  |  |  |
| --- | --- | --- | --- |
| **EMERGENCY CONTACT INFORMATION** | | | |
| Emergency Contact Name: | | Relationship: | |
| Cell Phone #: | Alternative Phone #: | | Which phone number do we contact first?  **Circle one:** *Cell phone* or *Alternative #* |

I certify that the above information is correct and that I give Integrative Psychiatry Services permission to render services to me and to release information about me to insurance carrier(s) for payment and medication approvals. Additionally, I acknowledge that I have been presented with a copy of Integrative Psychiatry Services privacy practices (HIPPA).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Patient/Guardian Signature Date**

**HIPAA – a.k.a. “SUMMARY OF PRIVACY PRACTICES”**

A federal regulation called HIPAA requires that you be given information about how your personal health information is handled. This Act requires so much information, in fact, that it is difficult to condense all the information into a concise form for you to sign. For the detailed version of HIPAA, please visit [www.hhs.gov/ocr/privacy/index.html](http://www.hhs.gov/ocr/privacy/index.html).

In this document, we have attempted to explain what you *really need to know*.

**YOUR RECORD AND CONFIDENTIALITY**

Integrative Psychiatry Services (IPS) will not send your medical information out, or provide information about you to someone else, without your written permission (which you can later revoke at any time). IPS *is* allowed to *receive* information about you from others, though we are *not* allowed to confirm that you are a patient of ours. IPS must take care to not reveal information about you in the process of listening to others. Examples of IPS receiving information about you include receiving a voicemail about you from a family member.

There are three main exceptions to the complete confidentiality of your records:

**EXCEPTIONS TO CONFIDENTIALITY**

1. **LEGAL**: A court may subpoena your records, which means they are forcing IPS to give information about you, including talking to some opposing attorney on the telephone or in court. You get to object first, in court if necessary. The HIPAA rule also says “law enforcement” may request information for public safety purposes. IPS will handle these requests with great restraint and skepticism.
2. **DANGER:** If you or someone else is in danger, a health provider is *legally required* to reveal information about you, if it is thought necessary to protect you or another person. Examples of this include you informing a clinician that you intend to kill yourself or someone else.
3. **ABUSE:** When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is *legally required* to take steps to protect the child, and to inform the proper authorities.

**YOUR RECORDS IN THE COURSE OF BUSINESS**

Several people may handle paperwork at your insurance company—at minimum the billing people and those who actually send the check. However, there is generally no reason for these people to look at, or ask for, any details about your situation. These people will see only a diagnosis code and evidence of treatment (e.g. date of treatment and duration of visit). Sometimes their “utilization review” coordinator will see more information, including information in your medical record such as symptoms, medications, and response to treatment.

**PLEASE BE AWARE**

If you utilize your insurance for reimbursement of services or *for prescriptions*, this information will enter an insurance information bureau. This may have consequences for you later if/when you apply for new insurance policies (i.e. not only for health insurance, but also for life and/or disability insurance). Therefore, if you truly want to keep your information confidential, it is recommended that you pay out of your own pocket for psychiatric care and for psychiatric medications.

**I have received Integrative Psychiatry Services’ Summary of Privacy Practices**

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR ASSESSMENT & TREATMENT**

This is a legal form authorizing us to evaluate you, treat you, and an agreement between us that should any dispute arise in the future we will use arbitration to solve it. You must sign at both locations before you can be seen by a provider here.

**CONSENT FOR ASSESSMENT & TREATMENT**

I understand that as a patient at Integrative Psychiatry Services (IPS), I may receive a range of mental health and wellness services. The type and extent of services that I receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me.

I consent to participate in the evaluation and treatment offered to me by IPS. I understand that either IPS or I may discontinue treatment at any time.

Though my provider will do his/her best to fully advise me on the pros and cons of treatment options, I understand that it is also my responsibility to speak up and ask questions if I am confused about any of the recommended therapies. I acknowledge that there is no guarantee that I will be cured, or that a given treatment will be effective for me personally. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARBITRATION**

Arbitration means you waive your right to a jury trial. Due to the high costs of medical malpractice insurance and litigation, this office requires every patient sign an arbitration agreement. This means that all potential disputes are resolved through arbitration and not in court. This is mandatory for anyone who chooses to be a patient in our practice.

**ARBITRATION AGREEMENT**

Agreement between the patient signed below (or patient's designated guardian) and the clinicians of our practices: In the event of a dispute of any nature arising between the parties or their heirs at any time, as a result of clinicians providing medical services, advice, treatment, informed consent, prescriptions, tests and procedures whether in person or by phone, text, writing, internet, in the home, office, hospital or otherwise: The parties hereto agree to submit the dispute to binding arbitration under the rules of the Independent American Arbitration Association. An award rendered by the arbitrator(s) shall be final and binding upon the parties, and judgment on such award may be entered by either party in the highest court having jurisdiction. Each party hereto specifically waives his/her right to bring the dispute before a court of law and stipulates that this agreement shall be a complete defense to any action instituted in any local, state or federal court or before any administrative tribunal.

Any demand for arbitration under this Agreement must be made before the statute of

limitations applicable to such a claim has run.

**I understand that any testimony from an expert witness requires that the expert witness be board certified by BOTH the American Board of Psychiatry & Neurology (ABPN) and the American Board of Integrative Medicine (ABOIM, of the American Board of Physician Specialtiess).**

**ONLINE DEFAMATION AGREEMENT**

I also understand that anything I publish about Dr. Massoumi and/or her physician assistants or staff will be the property of Integrative Psychiatry Services and/or Dr. Massoumi and/or her assistants. I authorize Dr. Massoumi and/or her staff to request compensation in case I cause any unjustifiable bad publicity. I allow Dr. Massoumi and/or her assistants to publicly respond to answer the bad publicity.

**IT IS FURTHER AGREED**

1. In the event that I breach this agreement, damages including reasonable costs and attorney’s fees shall be paid to Dr. Massoumi.
2. In the event my claim is deemed frivolous, damages including reasonable costs and attorney’s fees shall be paid to Dr. Massoumi.
3. This agreement shall be binding on heirs, executors, administrators, successors, assigns, agents & attorneys.

**The patient represents that he/she is giving his/her consent knowingly and voluntarily without any element of force, deceit duress or other form of constraint or coercion, with a general knowledge of the medical and psychiatric procedures outlined above, is aware of the circumstances and is physically and mentally competent to give consent.**

IN WITNESS, the parties have signed this agreement.

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**►Notary Public Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT TO RELEASE/RECEIVE INFORMATION**

(This is the form that you need to complete if you would like to grant permission for us to obtain and/or share your information with anyone in your life. Even if you refuse permission, you must sign this form.)

I hereby grant my provider at Integrative Psychiatry Services to release and/or receive information from the following person(s):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SUGGESTED** | **NAME** | **CITY** | **PHONE** | **FAX OR EMAIL** |
| Primary Care Physician |  |  |  |  |
| Counselor |  |  |  |  |
| Spouse |  |  |  |  |
| Other family member (specify relationship) |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**OR** □ I do not give permission to anyone, except as described in the paragraph below.

I understand that the release of this information is for the purpose of enhancing the efficacy of my treatment.

**In addition, I give Integrative Psychiatry Services permission to release information about my dates of service, and the services that I received, to the following entities for the purpose of payment: my insurance carrier(s), the primary cardholder of my insurance card, and the credit card-holder listed on my “Credit Card Authorization Form”.**

**►Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FEE SCHEDULE AGREEMENT**

*Last revised 6/13/17*

**(**This document describes our fees for the services we provide, including a clear explanation of fees we charge for communications outside of appointment time, late cancellations or no-shows, and paperwork.)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **BCBS** | **Private Pay,**  **Seeing PA** | **Private Pay,**  **Seeing Dr. M** |
| **PSYCHIATRIC EVALUATION (90 Minutes)** | ~$260 | $325 | $475 |
| **MEDICATION REVIEW, TYPICAL (30 Minutes)** | ~$150 | $150 | $175 |
| **MEDICATION REVIEW, SHORT (<15 Minutes)** | ~$115 | $100 | $125 |
| **MEDICATION REVIEW, LONG (35+ Minutes** | ~$160 - $200 | $200 | $225 |
| **COMMUNICATION (phone or email) VIA RECEPTIONIST** | *free* | *free* | *free* |
| **COMMUNICATION (phone or email) WITH PROVIDER** | $3 - $5/min | $3/min | $5/min |

**I understand that I am responsible for paying all fees incurred at the time services are rendered.**

►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEES FOR NO-SHOW OR LATE CANCELLATION (i.e. < 24 hrs)**

* First Missed Appointment- $15
* Second Missed Appointment- $30
* Third Missed Appointment- Full Appointment Fee (“Medication Review, Typical”, see above)

*Please be aware that we will bill these charges directly to you, as insurance policies will not cover charges for late cancellation or no-show fees.*

**I understand that I will need to pay my missed appointment fee before I can make another appointment, and that my medical insurance will not reimburse me for this.**

►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEES FOR PAPERWORK (e.g. school or work letters, disability applications, etc.)**

**I understand that if I want my provider to complete paperwork, I will need to schedule an appointment for this.** (EXCEPTION**-** Simple forms which can be completed by office staff will be provided free of charge.)

►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**CREDIT CARD AUTHORIZATION FORM**

*Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Integrative Psychiatry Services, PC will keep all information entered on this form strictly confidential.*

*NOTE: We will not charge your credit card without your explicit consent.*

**PATIENT TO SIGN BELOW:**

If the name on the credit card is different from my own (e.g. if the below credit card belongs to my parent or spouse), I do hereby grant permission for Integrative Psychiatry Services to disclose information regarding appointment dates kept and missed to the credit-card holder as necessary in order to collect payment.

Patient’s Signature & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDHOLDER TO COMPLETE:**

NAME ON CARD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (e.g. parent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Integrative Psychiatry Services, PC, to charge my credit card for the amounts invoiced.

Type of Card: AMERICAN EXPRESS / VISA / MasterCard / OTHER

If other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CVC Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Billing Address

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the credit card holder, I also authorize Integrative Psychiatry Services, PC to charge my credit card for future services, communication (e.g. phone & e-mail) fees, and also for late cancellations or failed appointments.

Any disputes that I have regarding charges will be addressed directly with Integrative Psychiatry Services. I will *not* dispute the chargesto my credit card company.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Cardholder’s Signature Date

**PATIENTS WITH BLUE CROSS BLUE SHIELD (BCBS) OR PRIORITY HEALTH**

(If you are using your BCBS or Priority Health medical insurance to pay for your services here, you must sign the bottom of this document. This document states that you are responsible for knowing your insurance benefits and we are not. We will try to help you, but ultimately you are responsible.)

Patients using their BCBS or Priority Health insurance for any service provided by Integrative Psychiatry Services are responsible for knowing their own mental health insurance benefits.

Everyone’s insurance policy is totally different, so there is no way for us to be certain about your particular insurance coverage.

Just so you know, we do attempt to assist you in ascertaining your mental health benefits, and we are charged extra for this service.

However, this service sometimes provides us inaccurate information, and we are not responsible if our information is incorrect.

If you believe, and we believe, that a service provided by Integrative Psychiatry Services will be covered by your mental health insurance, but your insurance denies payment, then you will ultimately be responsible for payment.

*Non-covered services*: Please be aware that some of the services may not be covered or may be considered “not medically necessary” by your insurance and will be your financial responsibility. These include fees for no-shows, late cancellations, and communications with your provider outside of an appointment time.

*Co-pays/Co-insurances:* Copays (flat fees you are responsible for) and co-insurances (percentage of the full fee you are responsible for) are collected at the time of service and cannot be waived. For co-insurances we try to give you a “best estimate” of what the insurance might pay. Please note that once we receive payment from your insurance, the co-pay/co-insurance collected may need to be adjusted.

*Account balances*: Account balances of greater than $100 which are not paid within two months of the provided service may result in your inability to schedule future appointments with us, unless/until your balance has been paid off.

*Unpaid Balances*: Any balance of over 90 days may be turned over to a collection agency. Please contact our office if you are experiencing financial difficulty and cannot pay your balance in full to set up an individualized payment plan.

*Bank fees:* Your account will be charged for any insufficient funds checks, closed account checks or any other fee, we might incur as a result of a check written by you.

*Billing:* Questions regarding your billing may be directed to our office. If we cannot answer your question, we will refer you to our billing agency.

*Release of Information to Insurance:* I agree for Integrative Psychiatry Services to bill my medical insurance. Such billing mandates that we provide your insurance with dates of service, type of service (e.g. “psychiatric medication review”) and diagnosis code (e.g. “Major Depressive Disorder”). I understand that if I do not want my medical insurance to know that I am receiving psychiatric care, that I should not use my medical insurance to receive psychiatric services.

*Release of Information to Medical Insurance Primary Beneficiary (i.e. the name of the person on your insurance card)*: **I agree for Integrative Psychiatry Services to contact the primary cardholder of my insurance card, regarding the dates that I received service, for the purpose of notifying cardholder of co-pays, deductibles, and payments due.** In such instances, no specific details of my medical or psychiatric diagnoses will be disclosed.

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDI*CAID* OPT-OUT – ALL PATIENTS MUST SIGN THIS**

*Last revised 6/26/16*

(You must sign this document, specifying either that you do not have Medicaid, or that if you do have Medicaid you understand you are responsible for paying our full fees and will be ineligible to receive Medicaid reimbursement.)

**Please choose ONE:**

**□ I do NOT have Medicaid insurance, either as a primary or secondary insurance.**

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ I DO have Medicaid insurance, either as a primary or secondary insurance. (Please continue to read the rest of this form. Sign on the next page.)**

*Dr. Lila Massoumi, and all providers at Integrative Psychiatry Services, do NOT accept Medicaid. All patients who are on Medicaid, or are eligible for Medicaid, must sign a federally mandated “Private Contract” [i.e. this form] in order to receive services at our clinic. All services must be paid at the time of service, and neither Dr. Massoumi, Integrative Psychiatry Services, nor the patient may file a claim to* Medicaid *for reimbursement.*

This agreement is between all providers billing under Dr. Massoumi ("Physician"), whose principal place of business is 30300 Telegraph Rd Suite 310, Bingham Farms, MI, 48025, and patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ("Patient"), who resides at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is a Medicaid beneficiary seeking services covered under Medicaid. The Physician has informed Patient that Physician does not accept Medicaid.

Physician agrees to provide the medical services to Patient (the "Services") as listed on the “FEE SCHEDULE AGREEMENT”.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

* Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicaid program with respect to the Services, even if covered by Medicaid.
* Patient is not currently in an emergency or urgent health care situation.
* Patient acknowledges that neither Medicaid’s fee limitations nor any other Medicaid reimbursement regulations apply to charges for the Services.
* Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicaid program, and other supplemental insurance plans may likewise deny reimbursement.
* Patient acknowledges that s/he has a right, as a Medicaid beneficiary, to obtain Medicaid -covered items and services from physicians and practitioners who accept Medicaid, and that the patient is not compelled to enter into private contracts that apply to other Medicaid -covered services furnished by other physicians or practitioners who have not opted-out.
* Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicaid claim for the Services and that no Medicaid reimbursement will be provided.
* Patient understands that Medicaid payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicaid if there were no private contract and a proper Medicaid claim were submitted.
* Patient acknowledges that a copy of this contract has been made available to him.
* Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDI*CARE* OPT-OUT – ALL PATIENTS MUST SIGN THIS**

*Last revised 6/26/16*

(You must sign this document, specifying either that you do not have Medicare, or that if you do have Medicare you understand you are responsible for paying our full fees and will be ineligible to receive Medicare reimbursement.)

**Please choose ONE:**

**□ I do NOT have Medicare insurance, either as a primary or secondary insurance.**

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ I DO have Medicare insurance, either as a primary or secondary insurance. (Please continue to read the rest of this form. Sign on the next page.)**

*Dr. Lila Massoumi, and all providers at Integrative Psychiatry Services, have chosen to “Opt Out” of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign a federally mandated “Private Contract” [i.e. this form] in order to receive services at our clinic. All services must be paid at the time of service, and neither Dr. Massoumi, Integrative Psychiatry Services, nor the patient may file a claim to Medicare for reimbursement.*

This agreement is between all providers billing under Dr. Massoumi ("Physician"), whose principal place of business is 30300 Telegraph Rd, Suite 310, Bingham Farms, MI, 48025, and patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ("Patient"), who resides at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program *effective on 2/2/15* for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the medical services to Patient (the "Services") as listed on the “FEE SCHEDULE AGREEMENT”.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

* Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
* Patient is not currently in an emergency or urgent health care situation.
* Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
* Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
* Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
* Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
* Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
* Patient acknowledges that a copy of this contract has been made available to him.
* Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Controlled Medication Agreement & Refill Policy**

(*rev 6/26/16*)

(This document delineates our practice policy as it pertains to controlled medications -- such as stimulants used to treat ADHD, or benzodiazepines such as Valium & Xanax).

Controlled Medications are governed by multiple federal and state laws and monitored through multiple agencies. Monitoring agencies include the Drug Enforcement Agency (DEA), Michigan’s Department of Health, Michigan Board of Medicine, and the Michigan Board of Pharmacy. Physicians and pharmacists themselves can monitor any stimulant prescription ever filled by a given patient or client (irrespective of payment type, including cash), by logging on to the Michigan Automated Prescription System (aka MAPS).

An unfortunate risk with controlled medications is the development of dependency, or engaging in medication diversion. For all of these reasons, we see our patients frequently and consider the ongoing risk-benefit ratio of the medications that we prescribe. This is the standard of care that you deserve.

SEVERAL GENERAL GUIDELINES:

The longest interval between visits for patients on stimulant medications (i.e. for ADD/ADHD) is three months.

**No prescriptions for controlled substances will be written for you unless you accept the following agreement.**

1. I agree to follow the dosing schedule prescribed to me by my doctor.
2. I will never share, sell or exchange my medications with anyone for any reason. This is a felony and very dangerous.
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medication as I would any valuable possession. I know that my doctor at Integrative Psychiatry Services may not replace lost or stolen prescriptions of controlled medications in the absence of a filed police report.
4. The maximum quantity of stimulant medication that may be dispensed is a ninety-day supply. Even if you are stable on the medication, an evaluation of your progress on these medications needs to take place at least every three months. It is unlawful to phone or fax these medications or medication refills into a pharmacy.
5. Stimulant medications prescriptions expire sixty days from the date on the prescription. (In contrast, prescriptions for non-controlled substances are good for 12 months.)
6. I understand that medication refills for stimulant medication require a scheduled appointment with my primary doctor in the office. For this type of medication, refills cannot be called into a pharmacy and dosages will not be adjusted by phone.
7. I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time.
8. Integrative Psychiatry Services’ medication refill triage hours are 9:00 am to 5:00 pm, Monday through Friday for Non-Emergency refill requests. I understand that it may take up to 48 hours before I receive a response to my request for a prescription refill. Therefore, since my prescription can be expected to run out every month, I should make an appointment in advance. I understand that poor planning on my part does NOT constitute an emergency on the part of IPS.
9. I understand Integrative Psychiatry Services reserves the right to perform a urine or blood drug screen at any time while I am being treated with a controlled substance. If I do not comply with a drug screen within twenty-four hours I will be dismissed from the practice.
10. I understand that dealing with a forged, falsified, or altered prescription will result in a report to the police.

**►Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ELECTRONIC COMMUNICATIONS RELEASE**

(In today’s world, you may want to send or receive e-mails and/or text messages from us. This document describes how our practice handles these electronic communications.)

**E-MAIL**

E-mail can offer an easy and convenient way for patients and doctors to communicate. If you decide to e-mail us, here are some things for you to know:

* E-mail is *not* confidential. E-mail is like sending a postcard through the mail. My staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a *legal right* to read your e-mail if he or she chooses.
* E-mail communications become part of your medical record and will likely be printed and placed in your chart.
* E-mails may be forwarded to my staff for handling, if appropriate.
* E-mail should be limited to a brief question, requiring a one sentence response.
* If you have a question about changing your medication regimen (stopping, starting, changing dose), you will need to schedule an appointment, since e-mail communication will not be adequate to fully inform you of the risks and benefits.
* E-mail is never, ever, appropriate for urgent or emergency problems! In an emergency, please dial “911”, or go the nearest Emergency Room.
* If you agree to the option of communication via e-mail:
  + We will not spam you.
  + You can have automatically-generated appointment reminders e-mailed to you (which you may opt out of).
  + You can receive your bloodwork via e-mail, at your request.

**PLEASE CHECK ONE:**

**** I DO want to communicate with my clinician (dba Integrative Psychiatry Services) electronically. I have read the above information and understand the limitations of security on information transmitted.

* **E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**** I do NOT want to communicate with my clinician electronically. However, if I do e-mail my clinician (or IPS), I am automatically authorizing IPS to e-mail me in return.

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TEXT MESSAGING**

You may choose to receive appointment reminders as a text message to your mobile phone. This option is for your convenience. Be advised that text messages—like e-mails—are not encrypted to HIPAA-compliant standards.

**PLEASE CHECK ONE:**

**□** I DO want to receive appointment reminders via text messaging.

* + - **Patient Mobile Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - **Mobile Phone Carrier (e.g. Verizon, etc.)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I do NOT want to receive appointment reminders via text messaging.

**►Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Please give completed paperwork to receptionist and keep the remainder of the packet for your personal reference.**

**Handbook: What to Expect from Your Treatment**

*By Lila Massoumi, MD*

Dear Patient:

Thank you for allowing us to serve you on your journey towards wellness.

This handbook explains how we do things, and provides tips and guidance. We hope that you find it useful.

**FREQUENCY AND NATURE OF VISITS**

* Your first visit with us, called the psychiatric evaluation, will be 90 minutes. Time-permitting, you will receive lots of education. ***Feel free to take notes!***
* Your follow-up appointment with us, called a medication review, will be 1 – 6 weeks after your initial visit, lasting 20 - 30 minutes.
* After each appointment you will receive a **printed treatment plan**. Please follow the instructions on your treatment plan closely. (NOTE: Whenever there is a contradiction between the instructions on your treatment plan, and the instructions printed on your medication bottle, *the treatment plan takes precedence.)*
* As you begin to feel better, the interim between your appointments will be gradually increased, and may become as infrequent as every 4 – 6 months.
* Once you feel “very well” for one to two years, you may choose to transfer your psychiatric care to your primary care provider (PCP), and return to us on an as-needed basis.
* With few exceptions, ***if we do not hear from you for more than 6 months, we will assume you have moved on to a new provider***, and your case will be closed. Should you decide to return to us after your case is closed, *you will need to schedule another 90-minute appointment* to provide sufficient time for your provider to catch up on your life.

**MEDICATION TIPS**

**When to start a new medication**

* Start your new medication **on a day off from work or school.**
* If your medication is to be taken at bedtime, **start on a night when you have no work or school the following morning.** In this way, if you experience any unusual side effects, the medication trial will not interfere with your life responsibilities.

**Side effects**

* If you experience any unpleasant side effects (other than mild) we prefer that you err on the side of caution and **stop the new medication immediately.** Any medication which you have taken for less than one month is **safe to stop abruptly**.
* **Do *not* try to “tough out” unpleasant side effects.** We prefer that you listen to your body. If in doubt, STOP your medication.

**Allergic reactions**

* Signs of an allergic reaction can include a rash, hives, or itchiness. If you develop any of these symptoms, **please stop the medication** **and take Benadryl (diphenhydramine)** 50mg by mouth twice per day, and/or take whatever allergy medication you have available to you (e.g. Claritin, Allegra, or Zyrtec) and follow the instructions on the bottle.
* If despite taking an antihistamine, your symptoms persist, and/or **if you develop a fever or swelling of the face or throat, please call 911 or proceed to your nearest Emergency Department**.

**QUESTIONS FOR YOUR PROVIDER**

**Between appointments**

* Please **leave your question for your provider with the receptionist**. The receptionist will communicate with your provider when the provider is free, and call you back with the answer, usually within 24 hours.
* If you need to speak with your provider directly, **tell the receptionist that you want to make an “emergency phone appointment”** (whether same-day or next-day). Note that your insurance will not cover this communication time, and you will be billed as follows: $3/minute for physician assistant, or $5/minute for Dr. Massoumi. Occasionally, the provider may decide to make the first 5 minutes free, but this is at the provider’s discretion and we ask that you not expect this. (*See below for our rationale*.)

**Medication changes between appointments**

* If you decide you want to change your medication dose, switch to a different medication, or begin a new medication, **you need to schedule an appointment**.
* If you already have an appointment scheduled but it is too far off, **tell the receptionist that you want to make a sooner “emergency (or crisis) appointment”.** (*See below for our rationale*.)

***Rationale for making appointments***

*The reason you need to make an appointment to get your questions answered, or to change your medication regimen, is because what may seem to you like a “simple question” is to us complicated. To answer your question with the thoroughness that you deserve, your provider must review the following aspects of your chart: your psychiatric and medical diagnoses, your current list of medications and supplements (to avoid drug-drug interactions), your past psychiatric medications tried & failed (to avoid repeating past negative effects), your bloodwork (to ensure your kidney and liver are capable of metabolizing the medication correctly), and your personal preferences (e.g. “needs generics”, “wants to avoid weight gain”, or “sexual side effects are unacceptable”, etc…)*

**(WORK, SCHOOL, LEGAL) PAPERWORK FROM YOUR PROVIDER**

* If you need your provider to complete a form or write a letter, you need to **schedule an appointment**. During your appointment, your provider will collaborate with you to ensure that you are comfortable with what is being written about you.

**DIFFICULTY GETTING TO OUR OFFICE**

**Video teleconferencing** **with Facetime or Skype**

* Though we generally prefer to see you in person, we may in certain instances agree to see you via Facetime or Skype. This is a useful option for patients who are away on vacation, out of state for college, or live more than one hour away. Note, however, that neither Skype nor Facetime is encoded to HIPAA-compliant standards. Additionally, **patients using BCBS must be at least one hour’s drive from our office for BCBS to cover your appointment.**

**Saturday availability**

* Dr. Massoumi will occasionally have Saturday appointments available. **On Saturdays, only the South entrance by Buffalo Wild Wings is open.** Note that if you are running late or need to cancel last-minute, there will likely be no receptionist working to inform Dr. Massoumi.

**AFTER-HOURS EMERGENCIES**

* **This clinic does *not* have an after-hours answering service.** If you think that you might try to kill yourself, or kill somebody else, this is a PSYCHIATRIC EMERGENCY. Please call 911 or proceed to your nearest Emergency Department.

**MEDICATION REFILLS**

* You will be provided with enough medication refills to last until your next appointment. Therefore, you should not need to call us for a refill. If you do require a refill before your next appointment, we may or may not refill it (determined on a case-by-case basis). We are less likely to honor refill requests if you cancelled or (worse) no-showed for your last appointment with us.
* **We require 72 hours’ notice for all medication refills. Please plan ahead.**

**LABWORK/BLOODWORK RESULTS**

* We will review your lab results with you at your next scheduled appointment. The exception to this is if you are on Depakote or Lithium, in which case we will call you about any necessary dosage changes.

**PSYCHIATRIC CARE – DIFFERENT LEVELS**

* In an outpatient practice such as ours, appointments are generally no closer than once per week. In the event that you require psychiatric visits more frequently than once per week, we will refer you to a higher level of care. You may return to us once your condition is more stable.

**DISSATISFACTION**

* If at any time you become dissatisfied with any service you have received at our clinic, we implore you to bring your concern(s) (whether verbally or via e-mail) to the attention of someone/anyone at our center, including the receptionist(s), office manager, your provider, Dr. Massoumi, or anonymously via the Suggestion Box (wooden box on the waiting room coffee table). **Note that your feedback will be taken very seriously, as it is our clinic’s policy to actively engage in greater self-awareness and growth/improvement.**

**TERMINATION OF OUR RELATIONSHIP**

* Though our goal is to help you on your path towards becoming your best self, in certain instances we may decide to terminate our professional relationship. We may decide to terminate if we feel that you have abused our staff or providers, or if you consistently fail to comply with the treatment plan (and we are concerned that you are doing yourself more harm than good).