



Patient Information and Professional Service Agreement

Welcome to Providence Family Psychiatry. This document contains important information about our professional services and business policies. Please review it carefully and feel free to ask questions. Once all your questions have been answered, please sign at the bottom to indicate that you have read this contract and agree to its terms.

Services Provided

Successful psychiatric treatment depends upon close collaboration and open communication between psychiatrist and patient. While we will make every effort to help you reach your treatment goals, we cannot contract for a guaranteed result.

Length and Frequency of Meetings

Treatment begins with an initial consultation approximately 60 to 90 minutes in length, depending on complexity. During this meeting, we will explore your reasons for seeking treatment, review your psychiatric, social, and medical history, and begin to establish goals for our work together.

After our initial meeting, we may embark on a period of extended evaluation, generally two to four sessions in length, although this varies. During this time, we will continue to review your history, examine our unfolding therapeutic relationship, and determine how we can help you reach your treatment goals.

Mental health treatment involves regularly scheduled face-to-face meetings. Psychotherapy appointments (with or without medication management) are generally 50 minutes in length, while medication management visits are usually 30 minutes long. Occasionally these may be 15 minutes if clinically appropriate. The duration and frequency of our meetings may vary depending on your individual treatment goals.

Fee Policies

Please refer to the current fee schedule for details of pricing. A Good Faith Estimate, as required by the No Surprises Act for out-of-network services, is included in this packet.

Please note that as part of the initial evaluation, calls to obtain collateral information and review of prior records are included at no extra charge unless they extend beyond an hour of additional time. Please note that we do not charge for brief phone calls under 10 minutes, brief text exchanges, medication refills or brief responses to emails. This cost is

factored into our standard hourly rates. Extensive text or email exchanges taking beyond 10 minutes/day to address will be subject to being charged at the clinician's standard fees, prorated to 15-minute intervals.

Substitution of a phone or video-chat visit for an in-person visit is not always reimbursed by insurance companies for out-of-network clinicians. In the event of a planned phone or video session visit in lieu of an in-person appointment, the standard in-person appointment rates will apply.

If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if called to testify by another party. Because of the difficulty of legal involvement, we charge \$900 per hour for preparation and attendance at any legal proceeding. Please note that unless explicitly agreed upon at the start of our work together, our role is first and foremost as your clinicians and not as expert witnesses that render opinions for the courts. We cannot serve as both an impartial evaluator for the court and as your treaters. At times, we could be called to testify as a "fact witness" where we do not render opinions regarding the legal matter but could be called to state objective facts about our work together.

You may request a Good Faith Estimate of the cost of your care be provided in writing at any time. We reserve the right to increase fees in the future.

Payment

We accept all major credit and debit cards, as well as ACH/Wire Transfers. Payment is required at the time of service. We request that a credit card be placed on file and work with a credit card processor (Stripe or Square) that securely stores the information according to industry standards. Please note that once entered, we do not have access to the actual number other than the last four digits. We will charge the payment method on file at the time of the scheduled session according to our fee policies. Individuals who cancel or reschedule initial consultations may be re-booked at the discretion of the clinician. Typically, no more than one re-scheduling in advance is permitted for an initial consultation. Patients or the responsible financial party are responsible for any returned check fees.

As the subject of delinquent bills can be the source of difficulty in a psychotherapeutic relationship, if arrangements for payment have not been agreed upon, we have the option of terminating treatment and/ or using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

We understand that credit card fraud is common and from time to time we learn a charge has been disputed by the financially responsible party. We also recognize that billing errors can occur on our end as well. We ask that any disputes or concerns about billing be handled first by contacting us directly rather than disputing a charge with the credit card company. Disputing charges for services agreed upon and rendered due to not being satisfied with the results is not an effective way to address concerns and can disrupt treatment efforts and the therapeutic alliance.

Cancellations

If you need to cancel an appointment for any reason, please give at least 48 hours' notice. Otherwise, your cancellation may include a cancellation fee based on our three-strike policy. *First late cancels/no shows will be waived as a courtesy. Second late cancels/no shows will be half of the normal fee. Third and following late cancels/no shows will be the full fee. Cancellations towards any appointment type will be applied towards the three-strikes policy.*

Please initial here that you have read and agree to this policy: _____

Please be aware that insurance carriers will not reimburse you for cancellation charges. Regular attendance at our appointments is a key component of successful treatment and if problems arise with attendance, it is important that we work together to develop a feasible treatment plan. We in turn will make every effort to start sessions on time and will only cancel in the event of a personal or clinical emergency with as much notice as is possible.

For group therapy appointments after an initial trial visit, members commit on a month-to-month basis. Therefore, the 48-hour policy does not apply to ongoing group therapy. Members are paying to reserve a seat in the group for the month, thus contributing to overall group cohesion and viability. We recognize everyone will miss a session from time to time, but we expect people to prioritize attendance as much as possible. Patients may attend a group once on a trial basis, before committing to full enrollment.

Please note that you may receive automated confirmations and reminders of appointments. These notifications are a courtesy and technical glitches sometimes occur so in the event a reminder is not received, you are still responsible for keeping track of when your appointments are. Please feel free to contact us if you are unsure. Your signature of this document indicates you understand and agree to receive these communications.

Vacation and Time Away

It is our practice to take vacation and attend professional conferences or engage in other work travel. Whenever possible, we will give you advance notice regarding absences. We will arrange for coverage by another qualified clinician for urgent and emergent situations while away.

Insurance

At this time, we are out-of-network with insurance companies. Therefore, unless otherwise informed, you will be personally responsible for the full cost of your treatment. However, many plans (e.g. PPOs) will reimburse a portion of fees paid by patients to "out-of-network" providers. Most insurance companies will cover prescriptions and laboratory tests. Upon request we can provide you with a detailed statement called a "superbill" documenting services, diagnostic codes, and payments. This documentation can be submitted by you to

your insurance company for consideration for reimbursement.

It is your responsibility to understand your insurance coverage. Please contact your insurance company in advance of your first visit to determine what, if any, out-of-network coverage is included in your plan and what out-of-network deductibles must be met. You are responsible for notifying us promptly of any changes in your insurance plan.

Communication Outside Scheduled Appointments

Please feel free to contact your clinician(s) and administrative staff via phone call, email or text. Note that all members of your treatment team within our practice (therapist, psychiatrist, administrative staff) may have access to the voicemails and texts and they are considered part of the medical record. No one not involved in your care should be accessing these communications. Calls and texts are generally returned within 24 hours on weekdays, usually within the same business day. In the event of a life-threatening psychiatric or medical emergency, please go directly to the nearest emergency room or call 9-1-1 rather than waiting for a call back. Please ask to have your clinician called once you are safely in the emergency room. Do not call the administrative assistant in the event of emergency. Note that text messaging is also not for emergencies and text messages are generally not heard in the middle of the night.

We do not charge for brief contact (<10 minutes) outside of scheduled appointments as we do not want to discourage seeking help when necessary by attaching an extra cost to this type of contact. However, we do ask that you respectfully attempt to limit contact after-hours, and especially in the late evening and weekend hours, to urgent matters. If excessive or inappropriate communication outside scheduled appointments is interfering with effective treatment, we will address it during our scheduled appointments. Note that you can also call the national 988 Suicide and Crisis Line for additional support between sessions. We are not affiliated with this service and it should not be used for medical emergencies.

Email communication or messages via the AMD app/portal are for non-urgent administrative matters only, such as booking or changing appointments or requesting medication refills. Note that emails, portal messages and text messages are considered part of the medical record. While attempts are made to keep emails, texts and voicemails secure and confidential, security breaches can rarely occur over wi-fi and cellular networks so privacy cannot be guaranteed. If you choose to communicate with our practice by email, AMD messages or texts, you are acknowledging that they are not to be used for emergencies as a prompt response cannot be guaranteed and that there are limitations in security. We do use a HIPAA-compliant email server and will send any personal health information as an appropriately encrypted document.

If you do not give permission to receive SMS texts, voicemails or emails from our practice, please send us a message or email that states "I WOULD LIKE TO OPT-OUT OF COMMUNICATIONS" and specify which means of communication are not permissible. Otherwise, your signature of this document indicates you understand and agree to

receive these communications. You may opt-out at any time.

Social Media Policy

Please note that we do not accept “friend” requests or follow patients or their family members on our personal social media accounts. If we were already following each other on social channels prior to meeting, that is an exception. We may maintain professional social media accounts and anyone in the general public can follow these accounts should they choose to do so. Note that by “liking” or following a professional social media account of the practice or its clinicians, others may be able to see that you follow it. Please do not contact your clinician(s) via their professional social media accounts as these are not secure means of communication and may not be responded to in a timely fashion. Reserve contact to the HIPAA compliant methods outlined above. Clinicians may, especially in the case of emergency, review any public social media content that you are associated with if it could be relevant to treatment and your well-being. However, in non-emergent situations, we will discuss social media content together should you choose to share that dimension of your life in treatment. You may find our practice or providers listed on business review sites such as Google Reviews, Yelp or Healthgrades. Note that we will not respond to reviews left on these sites about your care specifically due to confidentiality. If you have feedback about the care you have received, we encourage you to address that directly with us rather than on these. If you would like to write a review, regardless of whether it is positive or negative, we encourage you to create a pseudonym and not include any personally identifiable details in order to preserve your confidentiality. We are committed to ensuring that our patients receive appropriate medical care.

Communication with Other Providers and External Entities

Physical and mental health are inextricably linked. Excellent mental health treatment often depends upon a team approach that involves frequent communication among all mental health and general medical providers as well as other stakeholders. In order to provide high-quality care, we will frequently need to maintain contact with your medical (PCP and relevant specialists) and mental health (prescriber or therapist) providers. We will provide you with HIPAA-compliant Release of Information forms by which you can share with us your other providers’ or stakeholders’ contact information and give us permission to exchange information with them. Within our practice, we work collaboratively and meet regularly to discuss cases so by joining the practice, you agree to us communicating with other clinicians within our practice unless you specifically request that we do not, such as if you personally know one of our clinicians.

In the course of doing business, we may need to share your personal information with outside businesses such as insurance agencies, credit card processors and our electronic medical record vendor. Please note that when relevant we have Business Associate Agreements on file with these companies where they agree to uphold the standards of HIPAA to maintain your privacy. We only share the minimal information necessary to

conduct business.

Confidentiality

Confidence in patient/doctor confidentiality is an essential component of mental health treatment. Information that you share with our practice will be kept strictly confidential and will not be disclosed without your consent. A written release of information is usually required for the transfer of information, except as discussed below.

To provide optimal care, we may need to discuss your treatment with a colleague. In this case, we will take pains to conceal or disguise identifying information, including using a pseudonym or first name only. In addition, we may receive peer supervision from other clinicians within our practice but no one from our practice will access your chart unless involved in your clinical care.

There are some exceptions where we may share information without your authorized release. For example, we are required to report abusive treatment and/ or neglect of a child, elder, or disabled person to the proper authorities. We must report the threat of serious bodily harm to oneself or others and take appropriate steps to prevent it. We may seek a patient's hospitalization in order to protect the individual. If warranted, we may notify the potential victim of a threat, as well as the potential victim's family members or police. In some legal proceedings, upon the order of the court, we may be obligated to testify or render records of your treatment. If a patient or a member of their family brings legal action against any of us and/or the practice, information may be disclosed if necessary and relevant to the case. For patients under the protection of a legal guardian, we will need to report general feedback on treatment progress to the guardian. In the event of non-payment of our treatment fees, we may need to disclose information to a collection service or small claims court. We also from time to time may share de-identified and anonymized data for the purposes of conducting research using real-world evidence and adhere to the highest standards for the de-identification of PHI.

Please note that loved ones or other concerned parties may at any time disclose information with clinicians at our practice. We are not able to confirm that a patient is under our care or provide other information without a signed release, except in case of emergency as noted above, but cannot reject information that is provided to us from people who know a patient. It is our practice to notify you if we do receive information like this from people in your life.

Please see our detailed Notice of Privacy Practices for further information.

Freedom to Withdraw

We each have the right to end treatment at any time. If you wish, at the time of termination, we will give you the names of other qualified mental health professionals or programs. If our practice or a clinician within our practice has made the decision to end treatment, we will generally provide a 30-day window of time to continue to provide coverage while new arrangements are arranged or until you meet with a new clinician, whichever comes first.

Please note that if you have not made an appointment with your clinician after 1 year from the last visit we will assume you no longer wish to be seen by the practice unless you have contacted us to make other arrangements. We will consider you discharged from the practice at that time. Most patients are seen at a minimum of every 3 months and if you have not been seen in over a year, we would likely need to repeat much of the intake process if you choose to re-enter the practice and this is at our discretion.

Informed Consent

I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I agree to enter treatment with Providence Family Psychiatry.

Signature: _____

Printed Name: _____

Date: _____

PROVIDENCE FAMILY PSYCHIATRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (“PHI”) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical health or condition, treatment, or payment for health care services and includes information that we have created or received regarding your health or payment for your health. It also includes both your medical records and personal information such as your name, social security number, address, and phone number.

I. OUR PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. Under federal law, we are required to:

- Protect the privacy of your PHI. All of our employees and clinicians are required to maintain the confidentiality of PHI and receive appropriate privacy training
- Provide you with this Notice of Privacy Practices explaining our duties and practices regarding your PHI
- Follow the practices and procedures set forth in the Notice
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples.

Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. **Psychotherapy Notes.** We do sometimes keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For our use in treating you. b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For our use in defending ourselves in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate our compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

- g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
- 2. Marketing Purposes. As a mental health practice, we will not use or disclose your PHI for marketing purposes.
- 3. Sale of PHI. As a mental health practice, we will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

- 1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- 2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
- 3. For health oversight activities, including audits and investigations.
- 4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.
- 5. For law enforcement purposes, including reporting crimes occurring on my premises.
- 6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
- 7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy/treatment versus those who received another form of therapy/treatment for the same condition.
- 8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
- 9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
- 10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

- 1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say “no” if we believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost-based fee for doing so as permitted by state law.
5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or healthcare operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say “no” to your request, but we will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Dated:9/9/2024

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature:_____

Printed Name:_____

TELEHEALTH INFORMED CONSENT

Telehealth is the delivery of psychiatric and other mental health and medical services using interactive audio and visual electronic systems where the clinician and the patient are not in the same physical location. **PROVIDENCE FAMILY PSYCHIATRY** allows its clinicians to perform telehealth when clinically appropriate using HIPAA-compliant platforms including Zoom. The interactive electronic systems used by these platforms 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 care
- Patient convenience
- Obtaining expertise of a distant clinician

Potential Telepsychiatry Risks:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by my clinician.
- Delays in 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 telehealth 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 telehealth sessions when I schedule follow-up appointments. If my clinician agrees, I will be scheduled for a telehealth session, and I will be sent an internet link 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 telehealth.
- (2) I understand that all the state rules and regulations which apply to in-person sessions also apply to telehealth sessions

(3) I understand that my clinician has the right to withhold or withdraw their consent for the use of telehealth 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 telehealth at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my clinician unless it becomes logistically impossible to continue care. Referrals will be made if that is the case.

My Responsibilities:

(1) I will inform my psychiatrist as soon as my session begins of my physical location and will not unexpectedly join from states where my clinician is not licensed. I understand the clinician may need to terminate the session should I join from a location where they are not licensed. Exceptions are made in the case of emergency/crisis or sporadic visits while traveling that are clinically necessary for appropriate continuity of care. I will also join from a safe and private location and not while driving or operating heavy machinery.

(2) 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 a working camera and audio input so that my clinician can see and hear me in real time.

(3) I will not record any telepsychiatry sessions without written consent from **PROVIDENCE FAMILY PSYCHIATRY**, and I understand that my clinician will not record any of our telehealth sessions without my written consent.

(4) I will inform my clinician as soon as my session begins if any other person can hear or see any part of our session.

(5) If I lose my connection during a session, I will immediately attempt to log back into the Zoom "waiting room." (6) If the audio I am receiving during a telehealth session is not complete and clear, I will attempt to let my clinician know or contact **PROVIDENCE FAMILY PSYCHIATRY** to schedule a new appointment.

Signature: _____

Printed Name: _____

PROVIDENCE FAMILY PSYCHIATRY, LLC

Tax ID: 3746023 Group NPI: 1477242915

5960 Fairview Rd, Suite 400
Charlotte, NC 28210

Patrick H. Harmon, MD NPI: 1740579432

Rates:

\$449 per hour for the initial consultation (usually 60-120 min).

\$249 / 30 minute follow-up

\$199/ 15 minute follow-up

Expert consultation, including forensic or legal document review, and preparation of significant documentation is billed at \$900/hour.

Appearances In court, depositions, and scheduled time addressing legal matters out of the office: \$900/hr

- These fees apply to all American Psychiatric Association DSM-5 diagnoses and corresponding ICD-10 codes.
- I use diagnostic codes that are clinically accurate, but these do not guarantee reimbursement.
- Most often therapy is done once or twice weekly, but sometimes more or less often.
- Most often therapy continues for six months, one year, or several years, but short-term, brief therapy for intercurrent issues is also common. As noted above, because of this variability, please ask me about what can be expected in your case.
- Most often medication management is done every one to three months, but sometimes more often at the beginning of treatment and during periods of acuity, and sometimes less often.
- Most often medication management continues for several years or even longer; because of this variability, please ask me what can be expected in your case.
- It is your right to determine your goals for treatment and how long you want to remain in therapy.

Required Disclaimers:

- Should you have additional questions about your rights under this act, you can contact any of the following: The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227) or visit <<https://www.cms.gov/nosurprises>> for more information about your rights under federal law. The Illinois Department of Insurance, Office of Consumer Health Insurance at (877) 527-9431.
- If you are billed for more than this Good Faith Estimate you have the right to dispute the bill. You may start a dispute resolution process with the U.S. Department of Health and

Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 days (about 4 months) of the date on the original bill.

- There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the healthcare provider, you will have to pay the higher amount.

If you have any questions related to billing, please contact us via the AMD messaging system or speak to your clinician.

By signing this form, you agree to pay the full fee at the time of your treatment, unless otherwise arranged or if your clinician is in-network with your insurance. If in-network any co-pays or co-insurance are due at time of service.

It is a federal requirement that each patient sign this form annually to begin/continue treatment.

Signature: _____

Printed Name: _____

Date: _____

Clinician Signature: _____

Clinician Printed Name: _____

Date: _____