CrossEssence Mental Health Care Group. LLC

OFFICE POLICIES AND FEES

Welcome to our practice, we look forward to helping you with your psychiatric needs. In order to help you understand the types of services that our clinic provides, we have listed the services and indicated, when appropriate, the types of services that are generally covered by your insurance plans. All other services are offered on a fee for service basis. When appropriate, our staff will help to process your insurance claims, however, please understand that our treatment relationship is with you. *In the event that you third party payer does not pay the claims, you will be responsible for the payment.* Please read carefully and feel free to bring up any questions you have.
Please read and initial each item:

_____**Psychiatric Assessment/Consultation -** 45 minute appointment, initial diagnostic assessment, review of prior psychiatric interventions, development of treatment plan. This type of appointment is usually covered by your insurance after a preauthorization process. *If preauthorization has not been given by your insurance company or you have not met your annual deductible, you be expected to pay in full at time of assessment.*

Adult Assessment (45-60 min) $300 **Child Assessment (60 min) $300**

_____**Medication Monitoring Appointment –** 15 minute appointment scheduled to assess progress on pharmacotherapy treatment and refill prescriptions or change current treatment plans. *This type of appointment is usually covered by your insurance plan.* **$100**

_____**Medication Monitoring Appointment (Extended) –** 30 minute appointment, scheduled for complex cases involving more detailed analysis. Also used when parents or other relatives are interested in providing or receiving additional information regarding a patient's treatment. *Generally this type of appointment in not covered by insurance.* **$175**

Fees not covered by insurance:

_____**Missed or cancelled appointments:** Patients will be billed for any appointments not canceled 24 hours in advance. Monday morning sessions should be canceled no later than Friday at 5pm. The fee for a missed session is the patient's responsibility, not the responsibility of the insurance company. Fees are:

- **1st missed appointment 50% of full fee**
- **2nd missed appointment 100 % of full fee**

_____**Triplicate Prescription (Controlled Substances):** Triplicate prescriptions should be obtained during scheduled medication monitoring appointments. There will be a nominal charge to process refill requests of medications that require triplicate prescriptions, such as Adderall, Concerta, Daytrana, Dexedrine, Metadate, Ritalin and Vyvanse. The fee is required for the
physician's time to review your chart, document the appropriateness of the refill, write the prescription or electronically submit if applicable. *Requests should be called to our office staff three (3) working days (72 hours) in advance and picked up in a timely*

manner (Mon-Fri 8am-5pm). Note that these prescriptions expire in 21 days. **$15**

_____**Non Triplicate Prescriptions:** Prescriptions are usually written during scheduled appointments. Refills are given to last until next scheduled appointment. If you have missed an appointment or do not have enough medication to last until your next appointment, *request routine refills should be handled by calling the office staff during working hour (8am to 5pm) or by calling you pharmacy and having them fax/phone a request to the office. Allow three working days (72 hours) for these refills to be processed.* The fee is required for thephysician's time to review your chart, document the appropriateness of the refill, write the prescription or electronically submit if applicable**.** **$15**

_____**Emergency Refill Requests:** Requests for medications to be refilled in a 24 hour time frame or in an emergency (i.e. after 5pm, weekends, and holidays) will be honored. *You will be assessed a charge* for the physician's time to answer you call, review the chart, document the appropriateness of the refill, call in the prescription (non-triplicate) or electronically submit if applicable. . This *is a service not covered by insurance.* **$75**

_____**Forms and Letters:**
Patients frequently request letters for school, work, special accommodation, legal matters and certain types of disability during medication monitoring appointments. Please keep in mind that you medical appointment is scheduled for the purpose of assessing your progress in treatment and response to medication. If time permits, brief forms requiring less than five minutes may be completed in your allotted appointment time. If you have a request for a letter to be written, you may schedule time with you physician in order to compose the letter. Your fee will be determined by the length of time and level of complexity required to complete this service.

- **Simple (less than 5 min) $40**
- **Moderate (10 to 15 min) $65**
- **Lengthy (20 to 30 min) $110**
- **Complex (30 to 60+min) $200/hr**

_____**Forensic Psychiatry:**
If you have requests for you psychiatrist to appear in court and testify on you behalf or consult with your attorney regarding custody, divorce, criminal charges, you must schedule a 45 minute appointment to discuss your needs, so that the psychiatrist can determine whether he or she will accept your case and provide the expertise that you require. *This service is never covered by health insurance.* Retained fees will be determined at evaluation. **$350/hr**

Review of Forensic Records and Professional Opinions $400/hr

Court Testimony and travel time for court appearance $500/hr

I have read the policies and fees notice and understand that if I request any services that are not covered by my insurance plan, that I will be billed accordingly.

_____ _____
Signature of Patient or Guardian **Date**

NEW PATIENT REGISTRATION AND HEALTH INSURANCE INFORMATION

GENERAL INFORMATION

Name: ……..**DOB**: ……..**Sex**: …….

Mailing Address: …….

City, State, ZIP: …….....

SSN:……...**Employe**r:…….....

Home Telephone:……. May we leave a message? Yes No o .

Work Telephone: ……..May we leave a message? Yes __ No____

Cellular Telephone:…….. May we leave a message? Yes___ No ___

E-mail: ……..May we send a message? Yes___ No ____

In order for any claims to be submitted to your health insurance company the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s)

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____Company Telephone: _____

Patient's Relationship to Subscriber: ____Self :_____Spouse:___ Child oOther: ____

Patient ID: _____Patient Birth Date:_____ Patient Insurance Group #:____

CONSENT FOR TELEHEALTH CONSULTATION

PATIENT: _____Date of Birth: _____

I have been asked by my physician to take part in a telehealth consultation provided via a two-way audio/video link.

I understand that:
My physician and I will meet through a secure video-conference system.
1. I can ask that the exam and/or audio/video link be stopped at any time.

2. I understand that this procedure will be done through a two-way audio/video link. I know that it will be equal to a face-to-face visit with my health care provider.

3. I understand that there are possible risks with the use of this technology. These include, but are not limited to:

a. Interruption or disconnection of the audio/video link

b. A picture that is not clear enough to meet the needs of the consultation.

c. The telehealth system is encrypted and meets HIPAA privacy standards, but there is a small chance that data security could be breached. If any of these risks occur, the procedure might need to be stopped.

4. I understand that this consultation will become part of my medical record kept by the healthcare provider. This consultation will not be recorded.

5. I understand that I must give my informed consent to participate in this consultation.

Signature of Patient: _____ Date: _____

The above release is given on behalf of patient, because he/she is a minor or has been determined unable to give medical consent.

Signature of Parent or Legal Guardian: _____Date: _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____