



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricervices.com

Phone: 682 314 7353 | Fax: 682 323 2001

CLINIC POLICIES AND PROCEDURES

Thank you for choosing Supportive Psychiatric Services (SPS) for your psychiatric care. In order to prevent any misunderstandings and to facilitate the treatment of all patients, the following clinical policies are provided to serve you better. For purposes of this notice, the use of the word “office” should be taken to mean Supportive Psychiatric Services. In all cases where the words “you” or “patient” are used, it should be taken to mean “the patient or their parent/legal guardian/guarantor”. **Please read the entire document before signing that you acknowledge and understand our policies.**

APPOINTMENT SCHEDULING & CANCELLATIONS

- The office provides appointment reminders as a courtesy service, but the reminder cannot be relied upon. It is the patient’s responsibility to provide up to date contact information and remember the time and date of the appointment.
- Please login on time for appointments. Patients expecting to be late for their appointments should notify the office. Patients who arrive more than 10 minutes after their scheduled arrival time, will not be seen, OR will be rescheduled.
- Patients are expected to notify the office of cancellation 48 business hours prior to their appointment. In case of no show, late cancellation, or late rescheduling, \$25 fee will be automatically charged to the credit card on file. This fee is not reimbursable by your insurance company. For any cancellation it is mandatory to send an email to psychiatryservices4u@gmail.com.
- Patients canceling or no-showing for 4 appointments in a year may be terminated from our clinic.

EMERGENCIES AND URGENCIES

- In the event of a life-threatening psychiatric emergency/urgency (suicidal urges, threats, or behavior; physically or verbally threatening behavior; or abrupt and severe medical changes) **CALL 911 IMMEDIATELY** or go to your nearest ER room.
- For non-urgent issues please call our clinic number or send a message via patient portal and every effort will be made to respond to your call within 72 business hours.
- **All non-urgent after-hour phone calls, including prescription refill requests will include a \$25 fee per 15 minutes. This fee is not reimbursable by your insurance company.**



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricservices.com

Phone: 682 314 7353 | Fax: 682 323 2001

MEDICATIONS REFILL REQUESTS / PRIOR AUTHORIZATION

- It is not advised that a patient abruptly discontinue any medications. Interruption of regularly scheduled medications can potentially cause unpleasant, sometimes dangerous withdrawal symptoms or a relapse of the condition being treated.
- Controlled substances will **NOT** be refilled without an office visit or telemedicine visit.
- Follow-up appointments must be scheduled and kept in order for a refill request to be approved.
- SPS does not send med refills out of state.
- The office staff will make every attempt to schedule the patient's follow up appointments, but it is the patient's responsibility to schedule the appointment in advance to avoid any refill fee. Any refills will be provided only during the appointment.
- All refill requests must be submitted via fax, call, or electronic request from your pharmacy.
- Please allow **72 business hours** for the refill request to be completed. Refill requests will **NOT** be processed on a weekend or holiday.
- Certain medications may require prior authorization from your insurance company. This may take several weeks, depending on your insurance plans. Please note that filing of an authorization does not guarantee your insurance will approve the request.
- There is a **\$30 fee** for each authorization that our office has to obtain. This fee must be paid before the prior authorization is processed. Prior Authorizations are typically done on Fridays or over the weekend.
- We advise each patient to obtain a copy of your formulary list prior to your visit to ensure that the medications are covered by your insurance company and to give you the opportunity to discuss alternatives if possible.
- New symptoms will require an appointment; the NP will not diagnose or change any medication via telephone or email.



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricervices.com

Phone: 682 314 7353 | Fax: 682 323 2001

- If you develop any adverse drug reaction, please inform SPS immediately. Please go to the nearest Emergency Room if symptoms are severe or life threatening. For any urgent concerns which can wait for 48 hours, all attempts will be made to address the issue as soon as possible by giving the earliest possible appointments.

INSURANCE AND PHARMACY BENEFITS

- A valid state issued photo ID and a copy of the insurance card(s) must be supplied by the patient or guarantor. It is your responsibility to contact your medical insurance plan to determine what benefits and services provided are covered or if the SPS provider is in their network.
- SPS is only able to accurately bill an insurance carrier when provided with correct information. It is the patient's responsibility to submit any change of insurance at the time of his or her visit along with the appropriate referral, if needed. This includes providing the office with a copy of the actual insurance card and your photo identification.
- SPS must be notified at least 48 hours prior to appointment of any changes in the insurance. New insurance without verification will result in a co-pay of the allowable amount designated by your insurance company.
- If billing errors occur due to the patient's failure to submit correct information, the office will not be held liable and it is the patient's responsibility to pay the full fee for the services rendered.
- Pharmacy benefits vary greatly from one plan to the other. SPS understands insurance restrictions and attempts to prescribe in a manner which is mutually agreeable to both patients and their insurance carriers. However, SPS cannot predict how any specific medication will be covered by a patient's plan. It is your responsibility to know about your pharmacy benefits, at the time of appointment.

CONTRACTED MANAGED HEALTH CARE

(HMOs, PPOs, EPOs) **It is your responsibility to make sure that our physician is currently enrolled with your plan. All Necessary referrals must have been obtained prior to each visit.** If your referral has not been completed prior to your arrival in the office, it may mean a delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the copay at the time of your visit.

FINANCIAL POLICY

- In consideration for the services to be rendered to the patient; the patient assumes full financial responsibility for the payment of the patient's account. SPS will collect your co-pay/co-insurance responsibility the morning of appointment, irrespective of the timing of the appointment during the day. SPS accepts all methods of payments except checks. If you are unable to pay during the morning of the appointment it will be rescheduled.
- You understand that you are financially responsible for all services whether or not covered by your insurance.
- You are responsible for all balances on the account, which your insurance has determined as the patient's responsibility based upon the benefits.



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricservices.com

Phone: 682 314 7353 | Fax: 682 323 20015

If your insurance company denies payment for services rendered by SPS on grounds that the services are not medically necessary, this consent allows SPS to collect payment from you for the services rendered. Your credit card will be automatically charged for the balance unpaid by your insurance company.

- If you choose to be a self-pay patient the full amount will be collected at the time of scheduling the appointment. If you do not show up for your appointment, then the NLCR fee will be charged as per our NLCR policy.
- Adult Patient Self-Pay rate:
 - Initial Psychiatric Evaluation: \$150
 - Follow up Appointments: \$70
- Child and Adolescent Patient Self-Pay rate:
 - Initial Psychiatric Evaluation: \$175
 - Follow up appointment: \$75 (An adult has to be present during the appointment).

FORMS & MEDICAL RECORDS POLICIES

Filling out any paperwork is at the sole discretion of the clinic. Clinic will need up to 2 weeks to fill out any type of paperwork.

The cost to fill out forms is based on time spent by the provider/office staff to complete the request.

Under 15 mins.	\$20
16-30 mins.	\$40
31-45 mins.	\$60
46-60 mins.	\$80

- SPS does NOT fill out long-term, short-term disability paperwork.
- Emotional Support Animal letters - **\$200**
- Medical Records Fee:
 - \$25 for retrieval of records and processing the request; pages 1-20
 - \$0.50 per page thereafter.
 - This does not include mail charges

LITIGATION POLICY AND FEES FOR COURT RELATED SERVICES

It is important to our practice that we accessible to as many patients as possible throughout the day. For this reason, we want to avoid at all costs being involved in any legal commitments such as ligations, Subpoenas, deposition, etc. on behalf of an individual patients' legal disputes. Legal commitments such as these takes our providers away from the practice, and in essence away from patient care. If any case you are to become involved in any legal proceeding during your care with our providers including but not limited to divorce and custody disputes, or personal injury lawsuit, you agree that neither you, nor your attorney, nor anyone acting on your behalf will subpoena records from our practice, or subpoena our clinic to testify in court, in a deposition or in any legal proceeding. If we are involved in your litigations or if your attorneys subpoena our providers or staff to provide medical records, testify in court or give deposition in violation of this agreement, we will have no choice but to comply. For this our providers will require compensation.

The Hourly charge for all time related court cases or litigation is \$600 per hour. You will be asked to sign a credit card Authorization and provide a valid credit card to ensure payment for the time we must spend



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricservices.com

Phone: 682 314 7353 | Fax: 682 323 2001

dealing with litigation, and by your signature below, you agree not to contest any fees that you are charged to your credit card as a result of this agreement, and specifically, this section of this agreement. If we are subpoenaed to provide records or testimony in violation of this agreement you acknowledge and agree that you will be billed for the provider's professional time including but not limited to preparation, record review, transportation charges (door to door), Waiting time, and spent time testifying in court or deposition regardless of which party issues the subpoena or requires us to testify. If we are required to testify in court or give a deposition in any Dallas/ Tarrant counties, we will charge a retainer in the amount of \$2400 (a minimum of 4 hours at \$600 per hour). If the testimony or deposition requires testimony or deposition outside of Dallas or Tarrant County, the retainer will be \$6000 (a minimum of 6 hours at \$1000 Per hour), which includes preparation time, travel time (door to door), and attendance at any legal proceeding. If the testimony or deposition exceeds the retainer of 4 hours (in Dallas/Tarrant County) or the retainer for 6 hours outside (Dallas/Tarrant County), we will bill each additional hour spent attending a court hearing or deposition and we will charge your credit card for the balance.

In order to go to court or give deposition, Providers needs to reschedule their appointments to clear their day, therefore there is a 48-hour cancellation policy for court depositions. For example, if the court appearance or deposition is scheduled for a Monday, this office must be notified of any cancellation no later than noon on the Thursday before. Any cancellation that occurs within the 48-hour time frame of court appearance or deposition are NONREFUNDABLE. We will accept cash, money order, Cashier's check, or credit card for payment of time related to court appearances or deposition. No PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. All payments are due 48 hours prior to the scheduled court appearance or deposition, and no later than 12:00 noon on us to return these charges to the credit card on file in our office unless you notify our office that you intend to make payment by cash, money order or cashier's check.

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

PATIENT AND STAFF SAFETY COMPLAINTS

- At SPS, we strive to provide excellent care to all patients and staff members. Health care relationship is mutual between a patient and staff members of our clinic. We do not tolerate any disrespectful behavior including not being limited to verbal disrespect and profane language, from our staff towards the patients and vice versa.
- If we fail to meet your expectations, please contact our clinic (682 314 7353) and ask for our Office Manager. If the manager is unavailable, please leave a message and someone or a provider will contact you within 7 business days.
- If you, as the patient fail to meet the expectations, and a staff member is disrespected the same rights are given to all our staff members to report to SPS management in writing regarding the patient's behavior. After that, the decision to terminate patient's services from SPS will be made by SPS management.

TREATMENT CONSENT POLICY

- I hereby consent to receive treatment from Staff of SPS for my mental illness which includes but is not limited to history and examination, diagnostic & prognostic testing, therapy, and any other recommended treatment regimen.



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricservices.com

Phone: 682 314 7353 | Fax: 682 323 2001

- I understand that my treatment plan will be explained to me during my office visit and that I have the right to refuse and/or discontinue the treatment at any time. I understand that I may be prescribed medications to help my mental or emotional condition. Any side effects of these medications will be explained to me during the appointment, and I can request for a printed copy of common side effects.
- In order to receive proper care, I must accept certain responsibilities. I am responsible for providing accurate and complete information about matters relating to the patient's health and for reporting changes in the patient's condition. I am responsible for following the treatment plan recommended by the provider and reporting any side effects to the provider. If treatment is refused or directions given by the providers are not followed, I am responsible for the actions and the consequences of those actions.
- I have requested services from the SPS on behalf of myself and/or my dependents. I hereby authorize SPS to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and safeguarded, and how you can obtain access to this information. Please review it carefully.

Supportive Psychiatric Services has a legal duty to safeguard your protected health information ("PHI") and keep it private. PHI constitutes information created or noted by this office that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or payment for such health care. This notice is required to explain when, why, and how your PHI would be used and/or disclosed by this office. Use of PHI is when information is shared, applied, utilized, examined, or analyzed within the office; disclosure of PHI is when information is released, transferred, given, or otherwise revealed to a third party outside of this office. With some exceptions, your PHI will not be used or disclosed more than is necessary to accomplish the purpose for which the use or disclosure is made. Following the privacy practices described in this notice is legally required. Any changes to these practices will apply to PHI already on file. Before any changes to policies are made, this notice may be modified and a new copy of it will be posted in the office and on the website. You may also request a copy of this notice from our office.

Your PHI may be used and disclosed for many different reasons. Some of the uses or disclosures will require your prior written authorization; however, others will not.

Uses and disclosures related to treatment, payment, or office health care operations do not require your prior written consent:

- **For treatment.** Your health information may be used to give you medical treatment or services. Your PHI may be disclosed to pharmacists and their assistants, and other professionals involved in your care to put in place a treatment plan and to carry out that plan. For example, your PHI may be provided to clarify medication instructions with a pharmacy, obtain prior authorization for certain medications from insurance entities, or disclose health information to physicians who provide follow-up care to you.
- **For health care operations.** Your PHI may be disclosed to facilitate the efficient and correct operation of this medical practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, conducting business or arranging for other related activities.



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricservices.com

Phone: 682 314 7353 | Fax: 682 323 2001

- **To obtain payment for treatment.** Your PHI may be used and disclosed to bill and/or collect payment for the treatment and services provided to you.
- **Minors.** If you are an unemancipated minor (i.e., not legally authorized to act as adult) under Texas law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal and ethical responsibilities.
- **Parents.** If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you in certain circumstances. If we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you. In some circumstances, we may not disclose health information about an unemancipated minor to you. If your child is legally authorized to consent for treatment, we may not disclose health information about your child to you without your child's written permission.
- **Other disclosures.** Your consent is not required if you need emergency treatment. In the event that this office tries to get your consent, but you are unable to communicate (e.g., unconscious), but it is reasonable to assume that you would consent to such treatment if you could, your PHI may be disclosed.
- **Required by law.** This office may make a disclosure to the appropriate officials when a law requires reporting information to government agencies, law enforcement personnel, and/or administrative proceedings.
- **Disclosure** may be compelled by a party to a proceeding before a court or an administrative agency pursuant to its lawful authority, or if a search warrant is lawfully issued to a law enforcement agency.
- **Health and safety codes and federal regulations.** Disclosure may be compelled by the patient or the patient's representative pursuant to Texas Health and Safety Codes or to corresponding federal statutes or regulations, such as the privacy rule that requires this notice.
- **To avoid harm.** PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person including yourself or the public. This includes when disclosure is necessary to prevent the threat of danger from occurring.
- **Child/elder abuse and neglect.** Disclosure may be mandated by the Texas child abuse and neglect reporting law or the Texas elder/dependent adult abuse reporting laws.
- **Threat of violence.** Disclosure may be compelled or permitted by the fact that you tell this office of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
- **Public health.** Disclosure may be permitted to public health officials, if required.
- **Health oversight activities.** This office may be required to provide information to assist the government in the course of an investigation or inspection of a health care Organization.
- **Specific government functions.** PHI may be disclosed as a matter of national security.
- **Worker's compensation purposes.** In certain circumstances, PHI may be provided in order to comply with workers' compensation laws.
- **Appointment reminders and health related benefits/services.** PHI may be used to provide appointment reminders.
- If disclosure is otherwise specifically required by law.

RIGHTS REGARDING YOUR PHI

You have the right to inspect and copy your PHI that is in our possession; however, you must request it in writing. You will receive a response within 15 days of our receipt of your written request. Under certain



SUPPORTIVE PSYCHIATRIC SERVICES

www.supportivepsychiatricservices.com

Phone: 682 314 7353 | Fax: 682 323 2001

circumstances, your request may be denied. If so, you will receive the reason for denial in writing. You also have the right to have the denial reviewed. The charge for copying PHI is allowed by state law. You have the right to ask that use and disclosure of your PHI be limited, but this office is not legally bound to agree. If your request is agreed to, those limits will be put in writing and abide by except in emergency situations. You do not have the right to limit the uses and disclosures that this office is legally required or permitted to make.

You have the right to choose how your PHI is sent to you. It is your right to ask that your PHI be sent to you at an alternate address. This office may agree to your request providing that the PHI can be rendered in the format you requested without undue inconvenience.

You have the right to amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request correction of the existing information or addition of the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of receipt of your request. Your request may be denied if the PHI is correct, complete, forbidden to be disclosed, not part of the records, or written by someone other than this office. Denials will be provided in writing. If approved, the change(s) will be made to your PHI.

I further understand that any person who receives the medical records, will not release any of the medical information disclosed by this authorization to any other person or organization without authorization signed by me for release of the information. In other situations, not described above, written authorization from the patient will be requested before using or disclosing any of your PHI. If you have signed an authorization to disclose your PHI, you may later revoke that authorization in writing to stop further disclosures.

If, in your opinion, your privacy rights have been violated, or if you object to a decision made about access to your PHI, you are entitled to file a complaint with Supportive Psychiatric Services, LLC by calling 682 314 7353, or by sending a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

I authorize SPS and or any third-party organization assigned to the account to contact me at the telephone number, cellular number or email provided. Contact regarding my health condition may be performed with the use of pre-recorded messages, automatic dialing service, electronic email, text messaging, artificial voice messaging or personal calls regarding health care related notices or my obligation of payment for services.

I allow Supportive Psychiatric Services, to leave a voicemail/text about PHI at the following numbers. If you chose to disagree with voicemail/text regarding PHI, exception to this rule will still apply to automated appointment reminders sent to the patient's phone/email. If you do not wish to receive automated reminders or messages, it is your responsibility to block those in your phone/email (check all that apply):

Name and signature _____

Date: _____