CONSENT FOR CARE AND TREATMENT

Please read the following information carefully. It is provided to explain our professional services and business policies.

PROFESSIONAL SERVICES

Psychiatric and psychological services include such things as consultation, medication management, and various types of psychotherapy. Recommended treatments are individualized for each patient. These treatments have benefits and risks. Discussing your emotions can cause uncomfortable feelings, but this can also lead to improvements in various aspects of your life. Likewise, medications that are recommended to you will have risks and benefits that will be discussed at the onset of their use.

TELEHEALTH

At the discretion of your provider, and in accordance with federal and state regulations, some of your services may be rendered by telehealth (secure video consultation). If you choose to receive this service, you must be physically located in the state of Indiana at the time the service is rendered.

APPOINTMENTS

Initial appointments are 60-90 minutes. Follow ups typically last 15 to 60 minutes.

COMMUNICATION WITH YOUR PROVIDER

Please call our office at the number listed below with any questions about your treatment plan or medications. Your provider is often not immediately available. At times, you may need to leave a voice message. Your provider will make every effort to return your call promptly, excluding weekends and holidays. Requests for medication refills will be submitted to the pharmacy during normal business hours and typically within 48 hours, so please plan appropriately. If it is an emergency, please call 911, go to the nearest emergency room, or call the Crisis and Suicide Lifeline at 988.

If you choose to communicate with your provider by email through the contact page of www.neighborhoodpsych.com, please understand that you are utilizing a form of communication that is not HIPAA compliant and the privacy of content you include cannot be guaranteed. We suggest you leave voicemails to maximize your privacy.

Referral Disclosure

During your treatment, there may be instances in which you are referred to other providers for certain services. Some common examples include labs, EKGs, imaging, therapy, or general medical concerns. The State of Indiana requires us to notify you of the following information regarding referrals:

- That an out of network provider may be called upon to render health care items or services to you during treatment.
- The out of network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under your health plan.
- You may contact your health plan before receiving health care items or services rendered by an out of network provider to obtain a list of network providers that may render the health care items or services and for additional assistance.

FINANCIAL POLICY & INSURANCE REIMBURSEMENT

It is the policy of Neighborhood Psychiatry, P.C. to request payment, in full, at the time of service. Cash, personal checks, and credit cards are the accepted forms of payment. We do not currently accept or process insurance. At your request, you will receive a billing statement listing the relevant information that is usually required by insurances companies for reimbursement. You may seek reimbursement from your insurance company at your discretion.

- Missed appointments and appointments cancelled less than 24 business hours in advance are subject to a charge equal to 100% of the planned service fee.
- The patient/doctor relationship may be terminated if there are 2 or more no-shows in 365 days.
- The patient may request a statement of all charges and payments at any time.
- A fee of $25 will be assessed for any returned checks due to insufficient funds. Should the accounts be sent to collections, the patient is responsible for any associated fees, including legal.
- To be eligible for Telehealth the patient must keep a valid credit card on file with Neighborhood Psychiatry.

APPOINTMENT REMINDER PREFERENCE

I prefer to receive automated appointment reminders in the following way:

☐Text ☐ do NOT send me appointment reminders ☐Telephone (may leave voicemail)

To the following phone number: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am a patient, or the parent or legal guardian of a patient, of Neighborhood Psychiatry P.C. I hereby acknowledge receipt of Notice of Privacy Practices (also located at www.neighborhoodpsych.com)

I, the undersigned, do hereby consent to the policies noted above and give consent to Neighborhood Psychiatry, P.C. to provide evaluation and treatment to:

☐ SELF OR ☐OTHER:_____

_____

Signature Date

_____

Relationship to Patient (if other than self)

HEALTH QUESTIONAIRE

Please fill out this questionnaire prior to you first appointment. Doing so will allow us to get important information quickly as well as allow us to use your time more efficiently during your scheduled appointment. The information you provide will be kept confidential.

Patient Information:

Name: _____

Address: Street _____

City _____ ST _____ Zip Code _____

Age: _____ Date of Birth: _____/_____/_____

Telephone: Cell _____Other _____

Email Address: _____

How did you hear about Neighborhood Psychiatry? _____

Emergency Contact:

Please list someone other than yourself.

Name: _____ Relationship: _____

Telephone: _____

Marital History:

Relationship status: Single Married Divorced Separated Widowed Domestic Partnership

If married, length of marriage: _____ Spouse's Name: _____

Number of previous Marriages: _____ Lengths of prior marriages: _____

Reason(s) for divorce: _____

Educational History:

Highest level of education completed: _____

Occupational History:

Current employer: _____

Length of employment: _____ Type of Work: _____

General Medical History

List any allergies or medication intolerances you have:

_____

_____

List all medications you are currently taking, when you take it and for what reason.

Medication time of day Reason for medication

_____

_____

_____

_____

Please list any current or ongoing medical conditions for which you are being treated:

_____

_____

List the name, specialty and phone number of any doctors you are currently seeing:

_____

_____

_____

List any surgeries you have had in the past:

Surgery Hospital Date Reason

_____

_____

_____

List any other general medical hospitalizations you have had:

Reason Date

_____

_____

_____

Mental Health History

Briefly describe the nature of the problem for which you are seeking help:

_____

_____

_____

_____

Please list the mental health professionals you have seen in the past (psychiatrists, psychologists, social workers, therapists, counselors):

Name Locations Dates Reason

_____

_____

_____

_____

Please list any past psychiatric hospitalizations/partial programs you have been admitted:

Hospital Date Reason for treatment

_____

_____

_____

Please list any psychiatric medications you have taken in the past

Medication Date Reason for medication

_____

_____

_____

_____

Please indicate if there are any issues from your childhood/adolescence that you feel may be of significance (e.g. illnesses, school problems, parents' divorce, family conflict, history of any type of abuse, etc.)

_____

_____

_____

Substance Use History

Do you use tobacco or nicotine? ____No ____ Yes, if so, how much per day? _____

Do you use caffeine? _____No _____Yes, if so, how much per day? _____

Please describe your alcohol use:

Type of alcohol Amount How often

_____

_____

Please list any current or past use of other types of drugs:

Drug Amount used How often Last used

_____

_____

_____

_____

Have you ever been diagnosed with or treated for a substance use problem?

_____ No _____ Yes If so, where and when?

_____

_____

Family History (Psychiatric, substance abuse and medical history)

Mother_____

Father _____

Siblings_____

_____

_____

Children:

_____

_____

_____

Others: (grandparents, cousins etc.)

_____

_____

_____