LOGICAL
BEHAVIORAL HEALTH

OUTPATIENT PSYCHIATRY SERVICES CONTRACT

Welcome to our group practice. This document contains important information about our professional services and business policies. Please read it carefully and make note of any questions that you might have so that we can discuss them during our session. **Please sign your initials on the line provided following each section, indicating that you have read and agreed to our policies. When you sign this document, it will represent an agreement between you and the Logical Behavioral Health Prescribing Physician ("Provider").**

PSYCHIATRIC SERVICES: Psychiatry is the branch of medicine that focuses on the evaluation, treatment, and management of psychiatric conditions. Although treatment typically involves the use of medications, it does not always result in a prescription for medications. If a prescription for medications is given, it may not be for medications that an individual is seeking.

Pharmacological treatment of a psychiatric condition can have benefits and risks. Your Provider will discuss the potential for side effects with any medication prescribed. As with any medication, the best outcomes are a result of medication compliance, taking medication as prescribed, and avoidance of interaction effects through other over-the-counter medications, supplements, alcohol, or other recreational drugs.

The initial appointment will involve an evaluation of your needs. The Provider will be gathering information regarding your background, presenting difficulties, medical history, and current mental health symptoms in order to formulate a clinical diagnosis and treatment plan. Subsequent sessions will involve continued assessment of medications and side effects, and may involve changing, titrating, or in some cases, discontinuing the medications prescribed if you are not tolerating them.

_____ (please initial)

APPOINTMENTS AND CANCELLATIONS: The initial evaluation will be 1 hour for adults or 90 minutes for children. Follow-up appointments will be 25 minutes and frequency will be determined with your Provider at the end of your appointment. Medications are prescribed at the time of the appointment and you will be given enough medications until your next scheduled appointment. Please note that the Provider will not be able to extend your appointment time if you are late and, in the event that additional time needs to be scheduled, you will be responsible for the original appointment as well. It will be your responsibility to keep all appointments and to reschedule in a timely manner with respect to how much medication you have remaining. If you need to reschedule, we will do our best to reschedule you in a timely manner.

If you cancel an appointment or fail to schedule a follow-up appointment in a timely manner, it will be your responsibility to ask the Provider to send your prescriptions to your pharmacy. These types of prescriptions may incur an additional $30 charge per prescription and will be written at the Provider's discretion.

The scheduling of an appointment involves the reservation of time set specifically for you and the Provider. In the event that you need to cancel an appointment, **please inform the Provider of your cancellation by 12:00PM PST one business day in advance**. Please be advised that you are responsible for the **full session fee** for all missed and canceled appointments noncompliant with the cancellation policies. Illness is not an exception unless accompanied by medical documentation.

_____ (please initial)

PROFESSIONAL FEES: The fee for service is $500 for a 55-minute adult initial evaluation $650 for a 90-minute child or adolescent initial evaluation, and $250 for a 25-minute follow-up. If medications are lost, stolen, or if you have run out of medications due canceled or missed appointments, or failure to schedule a follow-up appointment, there may be an additional charge of $30 per prescription phoned in at your Provider's discretion. Any after-hours **non-emergency** calls or requests may be subject to a fee of $125 per 15 minutes (there will be no charge to report medication side effects).

In addition to regularly scheduled appointments, the Provider will charge at a rate of $500 per hour pro rata for other professional services, including but not limited to, telephone conversations lasting longer than 10 minutes, report writing, attendance at meeting with other professionals you have authorized, preparation of records/treatment summaries, and time spent performing other services requested. Please be advised that the Provider has 15 days to provide letters and treatment summaries, and 30 days to provide treatment records from the time of request. If you become involved in legal proceedings that require the Provider's participation, you will be expected to pay the professional rate even if the Provider is called to testify by another party.

_____ (please initial)

BILLING AND PAYMENTS: You will be expected to pay at the beginning of each session (via cash, check, or card), whether you are utilizing private pay or health insurance benefits. Health insurance companies will often cover a portion of the cost of psychotherapy. If you are planning on utilizing your health insurance benefits, please be advised that you may be expected to pay the contracted amount upfront, depending on your plan, deductible, and whether or not the Provider is in-network. On occasion, mental health insurance rates (i.e. contracted rates, co-payments/co-insurance rates, deductibles) may change during the course of treatment. Please be advised that should your rates change, you will be expected to pay the difference for these services.

Payment schedules for other professional services will be agreed to when they are requested.

You are responsible for ensuring that your account balance is paid in full. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the Provider will have the option of 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, such costs will be included in the claim. In most collections situations, the only information released is information regarding a patient's treatment, his/her contact information, the nature of services provided, and the amount due.

_____ (please initial)

INSURANCE BENEFITS: It is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it is your responsibility to determine whether or not you have coverage and what kind of coverage you have prior to each appointment. Please be advised that you will be responsible for any and all claims denied or unpaid by insurance. If you have questions about the coverage, call your health plan administrator. In order for you to receive your insurance benefits, you will be required to authorize the Provider to provide a mental health diagnosis and dates of service. The Provider may have to provide additional clinical information such as treatment plans, summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company records and the Provider will have no control over what they do with it once it is in their possession. It is important to remember that you always have the right to maintain a private medical record to avoid the problems described above.

_____ (please initial)

CONTACTING ME: The Provider may not be immediately available by telephone. In the event the Provider is unavailable, you may leave a confidential voice message. The Provider will make every effort to return your call within one business day, with the exception of weekends and holidays. Email and text are not secure ways of communicating personal and confidential information.

If you experience a side effect of a medication, you will contact your provider. If an emergency situation arises, you may go to your nearest emergency room or call 911. You may also call the Provider and leave a message stating the nature of the emergency and a telephone number at which you can be reached. The Provider will make every effort to return your call immediately. In addition to dialing 911, for immediate assistance, you may also dial 988, which is the National Suicide Prevention Lifeline. If the Provider will be unavailable for an extended period of time, a qualified professional will be available for you to contact during his or her absence.

_____ (please initial)

PROFESSIONAL RECORDS: The laws and standards of our profession require that the Provider keep treatment records. You are entitled to receive a copy or summary of your records. These professional records can be misinterpreted by untrained readers.

Therefore, if you wish to view your records, it is recommended that you review them in the Provider's presence so that you can discuss the contents.

_____ (please initial)

MINORS: If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request a verbal agreement from parents that they agree to give up access to your records. If they agree, the Provider will provide them only with general information about your work together, unless there is a risk that you will be seriously harmed, seriously harm yourself, or someone else. In this case, the provider will notify them of the concern. The Provider will also provide them with a summary of your treatment when it is complete. Before giving them any information, the Provider will discuss the matter with you, if possible, and do their best to handle any objections you may have with what the Provider is prepared to discuss.

_____ (please initial)

COMPLIANCE: You understand that it is important to keep medications safe, secure, and out of the reach of children. You understand that the use of drugs, such as heroin, cocaine, marijuana, or amphetamines/methamphetamines can result in adverse effects with your medications. If you are prescribed any new medications, you will let your provider know immediately. You will use only one pharmacy to get all your medications. If controlled substances are prescribed, you may be required to come in for drug testing or pill counts, if necessary. It is your responsibility to understand and accurately report the condition(s) being treated. The Provider will always discuss the potential side effects and expected outcomes with you. You understand that it will always be your responsibility to contact the Provider if you need a refill prior to your next appointment and/or to schedule a follow-up appointment if one is not already scheduled.

CONFIDENTIALITY: In general, the privacy of all communications between a patient and the Provider, including that of minors, is protected by law. Therefore, the Provider is not at liberty to release information to another professional or interested party without written permission except where disclosure is permitted or required by law. There are some situations in which the Provider is legally obligated to take action to protect others from harm, even if he or she has to reveal some information about a patient's treatment. Disclosure may be required in the following circumstances:

(1) When there is a reasonable suspicion of child abuse, elder abuse, or abuse of a dependent adult (i.e., an adult who relies on the care of others). In this case, the Provider is required by law to file a report with the appropriate state agency.
(2) If the Provider believes that a patient is threatening serious bodily harm to another, he or she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
(3) If the patient threatens serious bodily harm to himself/herself, the Provider may be obligated to seek hospitalization for him/her or to contact a family member or others who can help provide protection.
(4) When disclosure is required pursuant to a legal proceeding (i.e., court order).

(5) In the event that the services occurred in our practice. If a similar situation occurs, the Provider will make every effort to fully discuss it with you before taking any action.

The Provider may occasionally find it helpful to consult other professionals about a case. During a consultation, neither your name nor identifying information about you will be revealed. The consultant also is legally bound to keep the information confidential.

_____ (please initial)

TERMINATION: The Provider reserves the right to terminate therapy at his or her discretion due to nonpayment, noncompliance with treatment recommendations, conflicts of interest, nonparticipation in treatment, lack of progress in treatment, hostility or threatening behaviors, or if your needs are outside the scope of the provider's competence or practice. You also have the right to terminate therapy at any time. Unless special arrangements have been made, a duration of 30 days or longer with no clinical activity is subject to having your chart closed.

_____ (please initial)

CONSENT FOR TREATMENT

I, _____, authorize and request that _____, provide psychiatric assessments, examinations, treatment, and/or diagnostic procedures which are advisable during the course of my care as a patient. The frequency and type of treatment provided will be decided between me and my therapist.

I understand that there is an expectation that I will benefit from pharmacological treatment but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and compliance with medications as prescribed and compliance with any other recommended treatment, such as psychotherapy.

I understand that my participation in pharmacological treatment is completely voluntary and that I may terminate treatment at anytime. If I decide to terminate treatment, I will follow my provider's recommendations on how to discontinue medications appropriately.

I have received a copy of the *Outpatient Services Contract*. I understand that the purpose of these guidelines is to clarify the nature of our professional relationship.

My signature below indicates that I have read and fully understand the information in the *Outpatient Services Contract* and I agree to abide by its terms during our professional relationship.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian/Financial Guarantor's Signature Date

_____ _____
Provider's Signature Date