NEW PATIENT PAPERWORK AND AGREEMENT

I_____ declare I did not make any changes and have not edited in any way any of the documents received from The Institute for Advanced Psychiatry or downloaded from the website, except for signing and dating those documents

*Date*_____

PATIENT INTRODUCTION

Thank you for choosing the Institute for Advanced Psychiatry to help you with your healthcare needs. We look forward to getting to know you. Please read all of the information in the patient packet and let us know if you have any questions or require any assistance.

PATIENT INFORMATION

The more information we have regarding the patient, the better we are able to help. Therefore, it is important that the **New Patient Registration/Medical History** be completed as thoroughly as possible. This information may take time to complete so please make every effort to complete the forms prior to your appointment.

PROFESSIONAL SERVICES/BUSINESS POLICIES

Please be sure to read the **Privacy Policies, Consent for Treatment** and **Authorization to Release Information** carefully. These forms give details regarding our responsibilities to you as well as your agreement for proceeding with treatment. All relevant forms must be completed and signed prior to your appointment with Dr. Diana Ghelber, MD or your designated provider.
Please return the Patient Registration Packet via fax or email at least 24 hours before your appointment time. This makes it much easier for us to have everything ready for you on the date of your appointment. Thank meeting you!

Dr. Diana Ghelber, MD, PA & the Staff of the Institute for Advanced Psychiatry

6800 Harris Parkway, Suite 200, Fort Worth, TX 76132

www.psychiatryfortworth.com

P 817.659.7344

F 888.501.5249

PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and your access to it. Protected health information about you is obtained as a record of your visits or contacts with Dr. Diana Ghelber, MD and Staff for healthcare services. Specifically**,** *PROTECTED HEALTH INFORMATION* is information about you, including demographic information (name, address, age, etc.) that may identify you and may relate to your past, present and/or future physical or mental health condition(s) and related healthcare services.

Dr. Ghelber is required to follow specific rules for maintaining the confidentiality of your protected health information, the use of your information and how she discloses or shares this information to/with other healthcare professionals involved in your care and treatment. This Policy describes your rights to access and control your protected health information. It also describes how we follow those rules in the use and disclosure of your protected health information for the purposes of providing treatment, obtaining payment for the services you receive, managing our healthcare operations and for other purposes permitted/required by law.

YOUR RIGHTS UNDER THE PRIVACY RULE

The following is a statement of your rights under the Privacy Rule in reference to your protected health information. Please feel free to discuss any questions/concerns with the staff.

RIGHTS TO A COPY OF PRIVACY POLICIES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain. Upon request, you will be provided with a revised Notice of Privacy Policies.

YOUR RIGHTS TO AUTHORIZE OTHER USE AND DISCLOSURE

This means that you have the right to authorize or deny authorization for any other use/disclosure of protected health information not specified in this notice. You may revoke an authorization at any time except to the extent that Dr. Ghelber or her staff has taken an action in reliance on the use or disclosure indicated in the authorization. Any revocation of authorization to use or disclose protected health information must be presented in writing.

YOUR RIGHTS TO DESIGNATE A PERSONAL REPRESENTATIVE

This means that you may designate a person who then has the delegated authority to consent to or authorize the use or disclosure of your protected health information. Any notice of revocation of authorization/designation of a previously named personal representative must be presented in writing.

YOUR RIGHTS TO YOUR PROTECTED HEALTH INFORMATION

This means that you may inspect and obtain a copy of protected health information about you that is contained in your patient record. Under certain circumstances, we may deny your request. Any requests for copies of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means that you may request, in writing, that we not disclose any part of your protected health information for the purposes of treatment, payment for service you have received, or healthcare operations. You may also request that any part of your protected health information be restricted from disclosure to others who may be involved in your care or for notification purposes as described in this Notice of Privacy Policies. Under certain circumstances, we may deny your request for restriction. All requests for restriction of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST YOUR PROTECTED HEALTH INFORMATION AMENDED

This means that you may request an amendment of your protected health information for as long as we maintain the information. Under certain circumstances, we may deny your request for an amendment. All requests for amendment to your protected health information must be made in writing.

PRIVACY POLICY AUTHORIZATION

PLEASE INITIAL ALL STATEMENTS

You have certain rights regarding your protected health information under the Health Insurance Portability and Accountability Act (HIPPA). This document allows you to specify under what conditions your protected health information may be used or disclosed. HIPAA gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). Please initial what type(s) of information and for what purpose(s) you authorize us to disclose your protected health information.

_____ *I understand that Dr. Diana Ghelber, MD and the Institute for Advanced Psychiatry or another appropriate provider designated for your care, reserves the right to change notices and practices and that I will be given new notification, upon request, if this occurs. I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or healthcare operations.*

_____ *Dr. Diana Ghelber, MD or another appropriate provider designated for your care and staff may release any/all medical information needed to determine payment for services. I understand that without this particular authorization no claims can be filed with my insurance company and I will be responsible for paying in full for all medical services provided at the time of service*

_____ *I understand that I may revoke this consent in writing, except to the extent that Dr. Diana Ghelber, MD, or, another appropriate provider designated for your care, the Institute for Advanced Psychiatry and support staff have already taken action in reliance thereon. I also understand that Dr. Diana Ghelber, MD or another appropriate provider designated for your care, and the support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency*

Dr. Diana Ghelber, MD, or another appropriate provider designated for your care, and staff may release protected health information to HIPAA covered entities on my behalf. This includes, but is not limited to, health/insurance plans, other healthcare providers, healthcare claims clearinghouses and others.

_____ *I understand that I am also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home. Dr. Diana Ghelber, MD, or another appropriate provider designated for your care and staff may contact me in the ways specified below for general information (**Mark appropriate option**):*

Home ☐ **Phone** Cell ☐ **Phone** Work ☐ **Phone** Personal ☐ **Email** Home. ☐ **VM** Cell ☐ **VM** Text ☐ **Message**

*Dr. Diana Ghelber, MD or another appropriate provider designated for your care and staff may communicate verbally and/or via email with others (including but not limited to family members who may answer the phone/check email) regarding appointments, test results and other general information. Please initial the types of information you authorize Dr. Ghelber or another appropriate provider designated for your care and/or staff to disclose (**Mark appropriate option**):*

List all approved persons who can receive information on your behalf:

Name and Cell_____

Name and Cell_____

Name and Cell_____

I understand this release may include records that contain information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to Medicare, Medicaid or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or the patient's employer. (The patient's employer will only be contacted if necessary to confirm enrollment in a healthcare plan).I understand this release may include records that contain information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to Medicare, Medicaid or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or the patient's employer. (The patient's employer will only be contacted if necessary to confirm enrollment in a healthcare plan)

_____*I consent to receive* ***appointment reminders*** *in the ways specified below*

*(**Mark appropriate option**):*

Cell ☐ *Phone* ☐

VM ☐ *SMS* ☐ *Email* ☐

_____*I consent to receive* ***superbills*** *in the ways specified below*

*(**Mark appropriate option**):*

Email ☐ *In-Person* ☐

_____*I consent to receive* ***Laboratory Requisite*** *in the ways specified below*

Email ☐ In Person ☐

MY SIGNATURE BELOW SIGNIFIES THAT I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE NOTICE OF PRIVACY POLICIES. IN ADDITION I UNDERSTAND THAT THE ABOVE AUTHORIZATIONS MAY BE REVOKED AT ANY TIME BY WRITTEN NOTICE TO DR. DIANA GHELBER MD, PA. ANY REVOCATION WILL BECOME EFFECTIVE ON THE DATE IT IS RECEIVED BY THE OFFICE OF DR. DIANA GHELBER MD, PA. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT LIMIT THE TREATMENTS AVAILABLE TO ME; IT ONLY AFFECTS THE USE OF MY PROTECTED HEALTH INFORMATION. I ACKNOWLEDGE AND UNDERSTAND THAT USES AND/OR DISCLOSURES OF MY PROTECTED HEALTH INFORMATION BY HIPAA COVERED ENTITIES RECEIVING INFORMATION MAY OCCUR AND UNDER THESE CIRCUMSTANCES, I ABSOLVE DR. DIANA GHELBER MD, PA AND MEMBERS OF HER STAFF OF ANY RESPONSIBILITY AND/OR LIABILITY FOR SUCH USE AND/OR DISCLOSURE.

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GENERAL OFFICE POLICIES AND REGULATIONS

The following are the policies and regulations of this office and are followed without exception. Read them carefully. Initial each statement and sign below indicating that you have been made aware of them and that you agree to adhere to them. If you are a minor, parent or guardian signature is required.

PLEASE INITIAL ALL STATEMENTS

_____***CONSENT FOR TREATMENT*** *I, the undersigned, as the patient or on behalf of the patient do hereby consent to and authorize all diagnostic and therapeutic plan considered necessary or advised in the judgment of the physician . I*

understand that no guarantee or assurance has been made as to the results, which may be obtained.

_____ ***APPOINTMENTS*** *Services are by appointment only. In the event of an emergency, we will try to work you in. This may cause a wait and we ask for your patience in this regard. As a courtesy, we provide a reminder call and/or 2 reminder emails; however, it is your responsibility to be aware of your appointment date and time and to show up on time for that appointment whether or not you receive a confirmation call/email. We recommend that you show up early for your appointment and anticipate for traffic, weather conditions, etc. If you arrive late, we will not be able to give you additional time as your allotted time has been pre-scheduled and reserved for you. Arriving late for an appointment may not allow sufficient time for you to address any issues/concerns you wish to discuss with the doctor/technician.*

_____ ***CANCELLATIONS*** *In an effort to provide excellent service to all of our clients/patients in the*

best therapeutic environment, it is our policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment. The cancellation fee must be paid before my next scheduled appointment. If you have missed an appointment you will not be given another nor have your medications refilled until you have paid the missed appointment fee.

- *A fee of $100 will be assessed for missed/late-cancelled follow-up appointments*
- ***A fee of $100 will be paid before rescheduling a missed/late-cancelled initial evaluation appointment***

_____ ***REQUESTS FOR MEDICAL RECORDS*** *If you have an appointment with another provider or any other request that requires information, referrals and/or medical records , you must notify our office at least 7 business days prior to your appointment date. All information in your chart is strictly confidential and cannot be released to anyone without your written consent. Records can be transferred to another physician upon you written request. This usually takes up to thirty days and is done in the order in which their requests are received. Records transferred to any persons other than physicians, i.e., patients, lawyer, certain insurance companies, etc. are subject to a fee. The amount of this fee will depend on the volume of the record.*

_____ ***LETTERS/ ADDITIONAL PAPERWORK REQUESTS*** *The time taken to review and/or process patient paperwork (extensive medical records, reports, correspondence, chart notes, etc.) will be assessed a fee for the time spent on the paperwork. All letters to any person other than physicians will be subject to a fee starting from $40.00. Again, the exact amount will depend on the complexity of the document. Patients are expected to pay for all requested papers before they can be sent or picked up. An authorization to release healthcare records will be required before paperwork can be completed. Our office does not do paperwork regarding disability or court appointed paperwork. Please allow 10 business days to complete any requested paperwork.*

_____ ***BILLING/ CLAIMS*** *Dr. Ghelber, PA DBA Institute for Advanced Psychiatry, or another appropriate provider designated for your care are NOT contracted with insurance companies, and we do not file claims for the services you receive. It is your responsibility to ensure that we have all of the pertinent information to file claims with your insurance company. We will provide receipts containing procedure and diagnosis codes that may be submitted by the patient to insurance carriers for reimbursement. You may choose to submit claims to your insurance company. The reimbursement must be sent directly to you. You are responsible for contacting your insurance company and ensuring payment is sent to your address. Any insurance reimbursement we receive will be returned to sender. We will not be responsible or handle insurance reimbursement*

Please be aware that some commercial insurances will not cover the services provided.

_____ ***PAYMENT POLICY/ FEE AGREEMENT*** *The Institute for Advanced Psychiatry requires payment for services at the time they are rendered. If payment is not rendered at time of service you will not receive service. You will also be responsible for $100 fee. Payments may be made with cash, personal check or credit card. We do NOT take American Express.* ***There will be a $50 additional fee for all returned checks.*** *If you have any questions regarding payment and services you need to address this at time of service or no refund will be given. No refund will be given for rendered services. Patients are expected to maintain a zero balance. Accounts need to remain current in order to maintain ongoing treatment. Our office does not send patients invoices, but statements are available after each procedure. Please feel free to inquire about your balance before your account becomes delinquent. The patient/guardian is responsible for court cost, legal fees, or agency fees, which may be incurred in the collection of the account.*

_____ ***COURT FEES****: If a deposition or opinion in court is required there is $500 per hour charge, with a minimum charge of $2000 which must be paid in advance. IF Dr. Ghelber or designated provider is subpoenaed with less than 15 days notice is subject to an extra $2500 charge. We require a phone call from the patient or lawyer to notify the office*

_____ ***PHONE CONFERENCES*** *Patients are charged for time spent consulting with Dr. Ghelber on the telephone or the time taken for Dr. Ghelber to consult with other professionals regarding your treatment (with your permission). The fee charged depends of the length of the conference.*

_____ ***PATIENT RIGHTS*** *At any time, patients may question and/or refuse therapeutic or diagnostic procedures or methods, or gain whatever information they wish to know about the process and course of therapy. Patients are also assured confidentiality that is protected both ethically by the Institute and legally by Texas State Law. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions include the following: 1) The law requires notification of relevant others if it is judged that a patient has an intention to harm him/ herself or another individual. 2) The law obliges us to report any incident of suspected child abuse, neglect or molestation in order to protect the children involved. Confidentiality will be respected in all cases, except as noted above.*

_____ ***DEPENDENT PATIENTS*** *If you are requesting our services as the parent/guardian of a child under the age of 18 or as the guardian of a dependent adult, the same general practice as outlined above will apply. However, as the child or dependent adult's psychiatric care provider, it is important that the patient be able to trust the physician/technician. As such, the physician/technician will keep the content of the patient's sessions confidential in the same way that she would keep confidential the content of an independent adult patient's sessions. This is not only the clinic policy, but also a state and federal law. This is true even when the parent/guardian is financially responsible for the patient's appointments. In general, specific information that the patient provides will not be released, however it is appropriate to discuss with the parent/guardian, the patient's progress and the parent/guardian participation in their treatment and any issues that represent imminent safety concerns.*

_____ ***MESSAGES*** *The Institute for Advanced Psychiatry has regular business hours Monday- Thursday 8am-4pm. During this time, messages may be left for clinician with any of the office staff.* ***At any time:*** *-*
FOR LIFE THREATENING EMERGENCIES YOU MUST CALL 911 OR PROCEED TO YOUR NEAREST EMERGENCY ROOM.

THESE SITUATIONS SHOULD NOT BE HANDLED BY LEAVING A VOICEMAIL OR A MESSAGE FOR THE DOCTOR.

For URGENT MATTERS, which cannot wait until the next business day, you may call the office phone at 817.659.7344 and leave a voicemail or call the doctor on call. If you need to speak with Dr. Ghelber or another appropriate provider designated for your care Monday-Thursday after normal business hours you may call the office and dial 8. A fee of $75 will be assessed. On the weekends, you may contact the doctor on call whose contact information will be on the office line voicemail message. For all other matters, please call the clinic during normal business hours. Often, one of the office staff can handle your question and they will be pleased to assist you. Although your message is very important to us, please know that leaving multiple messages or emails will not speed up the process to receive a returned call. We check voicemails and emails periodically throughout the day and will contact you at our earliest convenience or, at the most, by the end of the business day.

_____ ***MEDICATION REFILLS/ AFTER HOUR*** *No routine prescriptions will be refilled after hours or on the weekends. Check your medications regularly and make sure that you have enough. Please allow 72 hours for prescription refill request to be processed. Our office is closed on Friday, all requests received after 4pm on Thursday may not be processed until Monday. If you miss your appointment or run out of medication because you did not schedule a timely follow-up appointment as agreed upon in the previous appointment, prescriptions will, in general, not be refilled until you have a scheduled appointment.* ***Due to administrative requirements on issuing CII prescriptions a fee of 20 dollars on will be implemented for requested between office visits.*** *If you are a patient prescribed Suboxone by Dr. Ghelber or another appropriate provider designated for your care you are required to follow the drug screen protocol that has been discussed. If you fail to follow protocol medication will not be dispensed. Be sure to notify Dr. Ghelber or another appropriate provider designated for your care if you are pregnant or think you may be pregnant. If you become pregnant while taking psychiatric medication(s), you will need to discuss the risks*

and benefits of the particular treatment(s) you are on with Dr. Ghelber or another appropriate provider designated for your care. In the case of an emergency please follow the protocol listed above.

_____ ***COURTESY*** *Dr. Ghelber or another appropriate provider designated for your care and her staff believe it is important to make everyone as comfortable as possible when visiting the Institute for Advanced Psychiatry. We ask that you put any mobile devices on silent and refrain from using them during your session. Should you need to take or make a telephone call while waiting, please step outside to avoid disturbing others. In addition, we try to create an environment of courtesy and respect for patients, physicians and staff. Please remember to be courteous to everyone while present in the clinic. Rude or disruptive behavior could result in termination of the physician-patient relationship. Every effort is made to begin appointments on time, but sometimes it may be necessary to wait. We appreciate your patience and understanding.*

_____ ***TERMINATION*** *At times, terminating the physician-patient relationship is necessary. Termination of psychiatric treatment may occur at any time and may be initiated by either the patient or the doctor. Reasons for termination by the physician are generally due to patient non- compliance with treatment(s), missed appointments, multiple cancellations, or, in rare cases, the inability to continue a therapeutic relationship. Dr. Ghelber or another appropriate provider designated for your care will continue to provide your care for 30 days after a notice of termination in order to allow you to find a new physician.*

_____ ***INACTIVE STATUS*** *The patient will only be considered an active patient if the patient keeps each appointment made or makes an alternative appointment with the office. After the passage of six months without an appointment between Dr. Ghelber or another appropriate provider designated for your care and the patient the patient will automatically be considered an inactive patient.*

Inactive status may be instituted if bills are not paid in a timely fashion. Inactive status may be institute after two appointments missed with less than 24 hour cancellation notice.

Inactive status designates that Dr. Diana Ghelber or another appropriate provider designated for your care will reserve the right to direct triage to another provider or facility if the need arises. Only emergency triage will be provided. If the doctor has prescribed medication continuously and inactive status starts, a maximum of one month of medication may be prescribed while the patient finds an alternative health care provider. If the doctor decided to reinstate you as an active patient, a new patient appointment will be required.

_____ ***Telemedicine*** *services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. 1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit. 2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room. 3.I attest that I understand that I have to be physically in Texas for my appointment and I will comply with this requirement 4. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit. 5. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services. 6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. a. I understand that my insurance carrier will have access to my medical records for quality review/audit. b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit. c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits. 7. I understand that this document will become a part of my medical record. By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language*

We trust that you understand the necessity for these terms, and we thank you for your cooperation. If you have any questions, do not hesitate to ask the staff or the doctor.

Please sign below, acknowledging that you have received the above information and agree to abide by the terms hereof.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATED GENERAL OFFICE POLICIES AND REGULATIONS OF DR. DIANA GHELBER MD, PA AND

Signature _____ Date _____

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F 888.501.5249

_____ _____

Client Signature Date