ADVANCED PEDIATRICS

100 EAST STREET, S.E., SUITE 301 • VIENNA, VA • 22180
PHONE: 703-938-5555 • FAX: 703-319-8580
info@advanced.pcc.com

MENTAL HEALTH AGREEMENT

1. Mental Health Providers work closely with our pediatricians to coordinate patient care and may share protected health information with one another. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:

    • medication prescription and monitoring
    • counseling session start and stop times
    • the modalities and frequencies of treatment furnished
    • results of clinical tests, summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date

2. Private therapy notes are considered confidential and protected under the law. They will not be shared with parents or pediatricians unless the mental health provider is concerned for the patient's safety or individual consent from the patient is received.

3. Patients receiving AP Mental Health services ***must*** stay up to date on their routine medical care (check-ups, asthma tune ups, etc.). If you are not compliant with your routine medical care, mental health services will be paused and/or terminated.

4. Intake evaluations will be scheduled after any anticipated trips. We cannot hold reoccurring appointments for those who will not be present on a consistent basis.

5. I acknowledge that my/child's Mental Health Provider with work with us to develop a recommended treatment plan. If I fail or refuse to follow through on their recommendations, the Mental Health provider reserves the right to discontinue their services and/or dismiss from the Mental Health Department entirely (in this event, I would still be able to continue seeing AP for Primary Care, but would have to seek Mental Health care outside of the practice.)

I understand the above information and will stay up to date with my (child's) routine medical care and communicate any anticipated trips with my provider

____

Patient/Parent's Name ***Patient/Parent's Signature*** ***Date***

ADVANCED PEDIATRICS

100 EAST STREET, S.E., SUITE 301 • VIENNA, VA • 22180
PHONE: 703-938-5555 • FAX: 703-319-8580
info@advanced.pcc.com

FINANCIAL RESPONSIBILITY FORM

We are currently credentialed with the most major private insurance companies. Your visit will be subject to specialist copays, deductibles, and/or coinsurance per your individual policy. Practice policies regarding copays and deductible deposits due at the time of service will apply. Please note that we cannot guarantee benefit coverage for primary care mental health services, and it is your responsibility to verify if your policy offers mental health benefits, and what your financial responsibilities are.

Please be advised that some plans have a specific behavioral health network associated with their benefits. We cannot guarantee that our mental health providers will be considered in-network. If your claim is processed out of network, you will be responsible for the balance due per your out of network benefits. Patients who do not have mental health benefits will be considered self-pay and payment will be due upon check-in.

Some plans require pre-authorization for mental health or nutrition appointments. It is your responsibility to verify your plan requirements and communicate those to us prior to scheduling an appointment. If you do not and as a result your plan denies coverage for the appointment(s), it will be your out of-pocket responsibility for the service rendered.

I acknowledge the fact that I am responsible for any copayment, coinsurance, pre-authorization, or deductible as it applies to my individual insurance plan and benefits*

____

Patient/Parent's Name ***Patient/Parent's Signature*** ***Date***

ADVANCED PEDIATRICS

100 EAST STREET, S.E., SUITE 301 • VIENNA, VA • 22180
PHONE: 703-938-5555 • FAX: 703-319-8580
info@advanced.pcc.com

CANCELLATION POLICY

Appointments that are canceled with less than 24 business hours advanced notice or no showed will be subject to a $100 fee.

We only have a limited number of appointments available and need to maximize our efforts to actively help as many of our patients as we can. Should you cancel with less than 24 hours' notice or miss 3 therapy appointments for any reason we will terminate therapy services in our office and refer you to other providers in the community for continued care. Please be advised that many community resources are not insurance credentialed and often have extensive waitlists.

I acknowledge and agree to the information above

____

Patient/Parent's Name ***Patient/Parent's Signature*** ***Date***

ADVANCED PEDIATRICS

100 EAST STREET, S.E., SUITE 301 VIENNA, VA 22180
PHONE: 703-938-5555 FAX: 703-319-8580
info@advanced.pcc.com

TELEHEALTH INFORMED CONSENT

I, _______________________________________, hereby consent to participate in telehealth with Advanced Pediatrics. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a patient who are located in two different locations.

Telehealth Requirements & Coverage:

Due to the COVID-19 pandemic, out of state telehealth regulations and insurance coverage for telehealth varies by individual states and policies. By signing this consent form, I agree to the following:

- *I will physically be in the state of Virginia at the time of my telehealth appointment. If I sign on to my telehealth session from another state where my provider is not licensed, I recognize that the appointment will be cancelled, and I will be charged a missed appointment fee of $100.*
- *It is my responsibility to verify my telehealth coverage with my individual insurance plan. If I fail to verify my telehealth coverage and my insurance denies coverage, I recognize that I am 100% responsible for the charges for the appointment.*

I understand the following with respect to telehealth:

- *I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.*
- *I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.*
- *I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions*

are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

- *I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).*
- *I understand that if the patient is having acute symptoms or experiencing a crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.*
- *I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the office at 703-938-5555 to discuss since we may have to re-schedule.*
- *I understand that my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.*

I have read the information provided above and discussed it with the office staff. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

____

Patient Printed Name   Date of Birth

____

Signature of Patient or Parent/Guardian   Date