

Stonebriar Psychiatric Services, P.A. Policies

OFFICE HOURS:

Sessions are by appointment only during regular office hours: Monday through Thursday, 8:00 a.m. to 4:00 p.m.

APPOINTMENTS:

Initial Psychiatric Evaluation appointments are 70-75 minutes, therapy sessions are 45-50 minutes, and medication follow-up appointments are 20 minutes. Fees are based on time and sessions that go over will be charged accordingly. With the exception of emergency situations over which we have no control, our appointments begin promptly as scheduled. Your appointment time is reserved for you and you are encouraged to be certain that you arrive on time. If you are late, you will cut into your appointment time but will be responsible for the fee for the full time.

APPOINTMENT CHANGES/CANCELLATIONS:

Patients are requested to notify the office of appointment changes or cancellations as far in advance of the scheduled time as possible to allow another patient to utilize the time. There is a required **minimum** notice of 24 business hours for individual sessions, a **minimum** notice of 48 hours for extended sessions (75, 90 and 120 minutes) and a **minimum** 1 week notice for scheduled intensives (over 120 minutes in one day) to avoid being charged for the time reserved. Monday appointments must be cancelled by the corresponding time on Thursday to avoid being a late cancel. If this minimum notice is not respected, patient will be charged the full fee for the time reserved. In the case of inclement weather, call the office first thing in the morning to see if the office has been closed. If not, and you are uncomfortable driving, you may have a phone session instead. In that case, you must call the office **prior to your appointment by at least 10 minutes and** give the receptionist your credit card information/authorization. Then, call back at your scheduled time to be connected for your phone session. Receipts will be e-mailed to you. If you do not call or come to your appointment, you will be charged.

If, for any reason, the doctor or therapist must cancel an appointment, the patient will be advised at the earliest possible time.

FEES AND PAYMENT:

Payment is required at the time of the appointment. We provide medically coded receipts for patients who wish to file for reimbursement on their own, but we do not deal directly with health insurance companies, nor do we complete or sign forms, provide treatment plans, or forward records. Depending on your individual coverage, you may qualify for benefits. You will need to check with your insurance carrier for details about your specific coverage. Please keep the documentation given to you at time of treatment. Additional copies will incur a fee to research and photocopy receipts. You may also use this documentation to file your claim if you participate in a cafeteria or medical reimbursement plan at your place of employment.

EMERGENCY CALLS:

During office hours, for calls that are urgent but not life threatening, please speak to the staff. For those that represent a life threatening emergency, always call 911 immediately or go to your local emergency room. When you are expecting a return call and your telephone **Caller ID** does not accept "Private or Blocked Calls", we will not be able to return your phone call. Please **unblock** your **Caller ID** prior to placing your call. Fees will be charged based on time required.

REPORTS, LETTERS, RECORDS, DISABILITY FORMS: May be provided at doctor's discretion and incur a fee, depending on the complexity of the document and time involved.

CONTACT POLICY:

In general, communication is to be kept to session times, however we recognize that there may be occasional exceptions to this. There will be a routine charge for phone calls, e-mails & letters, based on the time spent per event. For more extensive communication, please schedule a session with your caregiver.

Although we have e-mail available, patients are advised that e-mail transmissions are not secure and therefore not confidential. We will not conduct e-mail therapy sessions.

PRESCRIPTION POLICY:

If you have been given a controlled prescription, it is regulated by our state government. Please be aware that these prescriptions **must be filled within 7 days**, and no refills are allowed. If you do not fill the prescription in the 7-day time period, **there will be a \$20.00 fee to re-issue it. PRESCRIPTIONS FOR CONTROLLED SUBSTANCES CANNOT BE CALLED IN AND MUST BE PICKED UP OR MAILED.**

Take all medication as prescribed. As with all medications, these have been prescribed for you exclusively, based on knowledge of your personal needs and medical background. Sharing these medications is both medically contraindicated and illegal. Your cooperation is appreciated.

Prescriptions will **only** be called in for those who are *current patients and who maintain their regularly scheduled appointments*. Medication refills will only be called in during regular office hours and will not be called in over the weekend or holidays. All prescription refill requests must be called in a minimum of one full week before your medication runs out. There will generally be enough refills on your prescriptions to last until your next appointment; however, if that is not the case, Refills may be requested between 9:00 am and 4:00 pm on weekdays. **We will not be able to provide immediate refills to walk-in patients.** When requesting a refill, please provide all information regarding the prescription you are requesting, including your pharmacy name and number. Prescription refills incur a \$20.00 fee.

TERMINATION POLICY:

Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge that the doctor be notified in person during a session regarding this decision so that it can be discussed openly. Dr. Tharp’s goal is to make all terminations as therapeutically helpful as possible.

ACCEPTANCE OF POLICIES:

Stonebriar Psychiatric Services, PA is committed to providing professional services of the highest quality and standards. In order to serve our patients efficiently and responsibly we require agreements be made as to the policies stated above. Patients are encouraged to ask questions before signing.

I have read the policies, understand, and agree to abide by them.

Patient’s Signature

Date

Guardian’s Signature (if minor)

Stonebriar Psychiatric Services, PA.

GENERAL CONSENT FOR TREATMENT

I authorize my psychiatrist/therapist carry out psychological examinations, treatment and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

GENERAL CONSENT FOR TREATMENT (if patient is a child or dependent of beneficiary)

On behalf of the patient, _____ (name), I (the Legal Guardian or Legal Representative) legally authorize Stonebriar Psychiatric Services, PA to deliver mental health care services to the patient. I also understand that all policies in this statement apply to the patient I represent. **I acknowledge that my child's records are considered confidential except in the above stated exceptions.**

CONSENT TO TREATMENT SIGNATURE

Patient/Legal Representative

Date

Provider Signature

Date

Witness

Date

Welcome to Stonebriar Psychiatric Services, PA.

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy. If you ever have questions about the nature of the treatment or any other aspect of your care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The patient presents an imminent danger to self.
3. The patient presents an imminent danger to others.
4. Child/elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. Stonebriar Psychiatric Services, PA follows the “minimum necessary” rule when releasing information.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child’s case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment. I authorize that Stonebriar Psychiatric Services, PA providers may disclose any information, including drug and alcohol abuse and HIV status, regarding my or my child’s treatment for purposes of continuity of care. I know I have the right to revoke this authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without continuity of care, and may elect to transfer my care to another provider. This Authorization is valid as long as I am treated at Stonebriar Psychiatric Services, PA, or by my revoking the authorization.

Patient/Legal Representative Signature

Date

Witness

Date

Stonebriar Psychiatric Services, P.A.
Payment of Services and Missed Appointment Agreement Form

Our services are provided by appointment only and when a patient schedules an appointment, time is reserved for that patient and not available to others. Missed appointments, as well as those cancelled with less than a **minimum 24 business hours'** notice (48 hour **minimum** on extended sessions and 1 full week **minimum** notice on intensives, which are appointments including over 120 minutes scheduled in one day) will be charged the fee for the visit.

The fee for the visit will be charged on the day of the missed appointment to the following credit card:

Visa **MasterCard** **American Express** **Discover**

Credit Card #: _____

Expiration Date: _____

Name as it appears on Card: _____

Security Code from back of card: _____

I, _____, cardholder for the credit card listed above, understand and agree that if I or my family member do not show up for a scheduled appointment or if I cancel a scheduled appointment with less than a minimum **24 business hours'** notice (48 hour minimum on extended sessions **and 1 full week minimum notice on intensives, which are appointments including over 120 minutes scheduled in one day**) the *business hours'* notice, the above named credit card will be charged for the amount of the session.

Cardholder Signature _____ **Date** _____

Printed Name _____

Billing Address: _____

City: _____ Zip: _____ Day Phone _____

- ***To qualify for a timely cancellation on Monday appointments, the cancellation must be received by the corresponding time on the previous Thursday. Cancellations immediately preceding a holiday break must occur before the corresponding time on the last business day before the holiday. Voice mail and e-mail cancellations do not qualify as they can not be guaranteed as received.***

OPTIONAL AUTHORIZATION (separate authorizations may be completed if desired)

I would like for this same credit card to be used in the event of a phone session or other requested service for which I am not in the office (prescription refills, reports, forms, letters, etc) _____ (Initial your approval)

Use this card to pre-pay my appointment: _____

Use this authorization to charge services for my family member(s) who are also seen at the office. _____ (initial your approval)

All Family Members _____ (initial your approval)

Specific family member(s)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)