RIVER CITY PSYCHIATRY

4201 Springhurst Blvd, Suite 203
Louisville, Ky. 40241
Phone: (502) 425-6690
Fax: (502) 425-6629
www.RiverCityPsychiatry.com

Thank you for choosing River City Psychiatry for your mental health needs. Enclosed are complete instructions for what you will need to do before your appointment. Please fill out everything completely in order to maximize the time you will get to spend with your psychiatrist at your first appointment.

Before Your Appointment

The following things need to be completed and submitted BEFORE your appointment will be scheduled. You can choose to mail, fax, or drop off the completed information (see above for details). Your initial appointment will not be scheduled until this packet is received.

- ☐ **New Patient Information** – please fill out completely.
  - ✓ At the top of the page, circle which psychiatrist you would like to see. Please review our profiles on our website and select the psychiatrist best suited to fit your needs.
  - ✓ We submit prescriptions electronically, so make sure you have the information of the pharmacy you use (name, phone number, and address).
- ☐ **Signature Page** – please sign and return after you have carefully reviewed and understand our "**Policies and Procedures**" as well as our "**Privacy Policy**." These policies are available for review on our website under "Patient Forms." Please make sure to thoroughly review these.
- ☐ A copy of your insurance card

After we have received all of the above, our psychiatrist(s) will review the information, and our office will contact the patient.

Your First Appointment

- We strongly encourage you to use the "**Driving Directions**" on our website to direct you to our office as GPS/Online maps often lead you to an incorrect location
- Please plan to arrive 10-15 minutes before your scheduled appointment time.
- You must bring your photo ID, insurance card, and payment.
- Other things that are important to bring to your first appointment include:
  - A list of your current medications including dose, schedule, frequency
  - Previous treatment records that may be important for us. (This would include hospitalization records, psychological testing results, therapy notes, previous treatment records, etc.)
  - A list of all your medical conditions, if any, and medication allergies
- Expect your initial appointment to last up to an hour. Follow up visits are typically 15-30 minutes.

DISCLAIMER: A physician patient relationship is not established until completion of your first appointment. You will not be considered a patient of River City Psychiatry or its psychiatrists until then. Completing these forms does not guarantee an appointment. If we determine our services are not adequate to meet the level of care required, we will notify you as soon as possible.

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NEW PATIENT INFORMATION

PREFERRED PSYCHIATRIST (CIRCLE ONE): Pennington Wozniak No Preference

FIRST NAME _____ LAST NAME:_____ NICKNAME_____

ADDRESS: _____ CITY:_____STATE: _____ ZIP:_____

PREFERRED PHONE NUMBER: (_____)_____ OK TO LEAVE VOICEMAIL AT THAT NUMBER (CIRCLE ONE) YES NO

BIRTHDATE: ____/____/_____ RACE _____ SEX _____ MARITAL STATUS_____ SOC SEC #_____-_____-_____

EMAIL: _____ EMPLOYER_____

EMERGENCY CONTACT NAME: _____ NUMBER(_____)_____ RELATIONSHIP TO PATIENT:_____

HOW DID YOU HEAR ABOUT RIVER CITY PSYCHIATRY? : _____

PRIMARY INSURANCE COMPANY

NAME OF POLICY HOLDER:_____ BIRTHDATE: ____/____/____ RELATIONSHIP TO PATIENT:_____

ID #_____ GROUP #_____ INSURANCE COMPANY_____

PRIMARY CARE PHYSICIAN

NAME:_____ PHONE (_____)_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP:_____

THERAPIST OR OTHER MENTAL HEALTH PROVIDER

NAME:_____ PHONE (_____)_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP:_____

PHARMACY INFORMATION

NAME:_____ PHONE (_____)_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP:_____

REASON(S) FOR SEEKING TREATMENT: _____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)

MEDICATION NAME / DOSAGE / SCHEDULE (e.g AM, PM) / REASON FOR TAKING

_____

_____

_____

_____

DRUG/FOOD ALLERGIES:_____

MEDICAL CONDITIONS (CURRENT/PAST MEDICAL PROBLEMS, SURGERIES, HEAD INJURIES, ETC):_____

_____

_____

PAST TREATMENT HISTORY (*please elaborate on any "Yes" responses*):

HAVE YOU EVER SEEN A PSYCHIATRIST BEFORE? Yes No _____

HAVE YOU EVER HAD COUNSELING/THERAPY BEFORE? Yes No _____

HAVE YOU RECEIVED A PSYCHIATRIC DIAGNOSIS? Yes No _____

HAVE YOU EVER BEEN PSYCHIATRICALLY HOSPITALIZED? Yes No _____

HAVE YOU TAKEN PSYCHIATRIC MEDICATIONS? Yes No _____

HAVE YOU BEEN DIAGNOSED WITH DEVELOPMENTAL DELAYS? Yes No _____

HAVE YOU BEEN TREATED FOR ALCOHOLISM/SUBSTANCE DEPENDENCE? Yes No _____

HAVE YOU EVER ATTEMPTED SUICIDE OR TRIED TO HARM YOURSELF? Yes No _____

OTHER SIGNIFICANT PSYCHIATRIC HISTORY: _____

_____

_____

IS THERE ANY *FAMILY* HISTORY OF: (PLEASE NOTE RELATIONSHIP TO PATIENT)

DEPRESSION: Yes No _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: Yes No _____

ANXIETY DISORDER: Yes No _____

ADHD: Yes No _____

AUTISM: Yes No _____

OTHER MENTAL ILLNESS: Yes No _____

ATTEMPTED/COMPLETED SUICIDE: Yes No _____

ALCHOLISM: Yes No _____

SUBSTANCE ABUSE: Yes No _____

OTHER MEDICAL PROBLEMS (HIGH BLOOD PRESSURE, CANCER, SEIZURES, NEUROLOGICAL CONDITIONS, HEART PROBLEMS, DIABETES, ETC)_____

OTHER SIGNIFICANT FAMILY HISTORY: _____

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POLICIES AND PROCEDURES

CONSENT FOR TREATMENT: I consent to evaluation and medically necessary treatment by the psychiatrists of River City Psychiatry, LLC. I understand this consent does not constitute a guarantee about the results of my treatment. I understand I can terminate this consent for treatment at any time. I also understand that my psychiatrist may terminate consent for treatment at any time, and will discuss the reasons with me if this should occur. Potential reasons include misusing prescribed medications, misusing psychiatric services, etc.

LIMITATIONS OF RIVER CITY PSYCHIATRY: The psychiatrists at River City Psychiatry, LLC are dedicated to providing the highest level of care for their patients in treating and addressing their mental health needs. However, there are some services not provided in this practice:

- Forensic evaluations for legal purposes
- Custody evaluations, or parental assessments for use in determining custody or visitation
- Disability evaluations, including Short Term Disability and determining leave of absences from work
- Substance Abuse treatment

I understand that River City Psychiatry, LLC will not provide any evaluation for the sole purpose of seeking medical or mental disability, or assist in determining ability to take leave from employment. I understand I must find another professional to assist me in this purpose.

AGREEMENT TO PAY: I agree to pay my psychiatrist all charges for professional services. Payment is expected at the time of service, as balances are not allowed to accumulate. Any accumulated charges must be paid prior to any subsequent visit. Payments may be made via check, cash, debit card, major credit card, and Health Savings Account cards. Payments via credit card may be authorized over the phone.

FEES FOR SERVICES: I understand that my psychiatrist may or may not participate with my insurance company. This includes private insurance companies, Medicare, and Medicaid. The patient is responsible for payment in full at the time of service. The fee for an initial diagnostic evaluation, which is approximately 60 minutes is $275. The current fees for follow up appointments range from $85 to $200 depending on the services provided and length of session.

INSURANCE BENEFITS: I understand that my psychiatrist does not participate (is Out-Of-Network) with any insurance company. However, many insurance companies allow for Out-Of-Network provisions. In these situations, the patient is able to submit a form to their insurance company after each office visit, and may be partially reimbursed for their expenses. At the patient's request, your psychiatrist will provide you with the proper form to submit to your insurance company. It is the patient's responsibility to inquire about these services through their insurance company. If the insurance company requires any authorization from the psychiatrist, I understand I may be charged for this service.

Due to contractual limitations, the psychiatrists at River City Psychiatry, LLC are unable to treat any patient enrolled with Medicare or Medicaid, even if the patient does ***not*** intend to utilize these benefits. These patients are required to seek services from Medicare or Medicaid providers.

ADDITIONAL CHARGES FOR SERVICES: I understand there are additional services that may require billing as well. These include but are not limited to:

legal depositions, contact with attorneys
writing of reports for your insurance company or for your employer
obtaining Prior Authorizations for medications through your insurance company
returned phone calls longer than 10 minutes in duration, and excessive phone calls
returned checks (fee of $50), fees associated with collections

I fully understand that I will be personally responsible for these charges. The psychiatrist reserves the right to charge for these services on a prorated fee of $200 per hour, or may require the patient to schedule an office appointment to address these services.

INITIAL APPOINTMENT: It is the policy of River City Psychiatry, LLC for all persons interested in seeking treatment at our office to fully complete and submit the New Patient Information. After review from the psychiatrist, the patient will be contacted by our office. At that time, we will either schedule an Initial Diagnostic Evaluation or recommend alternative services. The current fee for an Initial Diagnostic Evaluation is $275. This fee reserves an hour of time with the psychiatrist and covers the expenses associated with the initial appointment. If the patient chooses to cancel the appointment without 24 hours notice, or chooses to cancel the appointment without notifying the office ("no show"), this fee is not refundable. If the patient desires to schedule an additional Initial Diagnostic Evaluation at a later time, this fee will again be required.

APPOINTMENT SCHEDULING: After an initial evaluation, it is standard of practice to schedule a follow up appointment within 1 month. Depending on each patient's psychiatric situation, follow up appointments could range from every week to every few months. It is expected that patients will be seen at least 3 times per year to remain active in the practice. Due to current legal restrictions in the state of Kentucky, patients receiving controlled substance prescriptions must be seen on a routine basis, typically every 2-3 months, depending on the prescribed medication.

CANCELLATIONS: I understand that when I schedule an appointment, this time is specifically allocated for me, as my psychiatrist does not "double-book" their schedule. By not keeping my appointment, I realize that another patient that may have needed to be seen urgently may not have been able to do so. Cancelled appointments must be made within 1 business day/24 business hours (for example, I must notify my psychiatrist by Friday at 10AM if my appointment is Monday at 10AM).

If a cancellation is not made within that time or is missed without notification, I will be charged the full fee for the appointment, and this fee must be paid prior to rescheduling an appointment with my psychiatrist. True emergencies are taken into consideration. Medication refill requests may not be honored if the patient has just missed or cancelled an appointment.

I understand that repeated late cancellation of appointments and/or failure to keep scheduled appointments may result in termination by my psychiatrist.

MEDICATIONS: Medications will only be refilled for current patients who maintain their regularly scheduled appointments and have account balances in good standing. All medication refill requests are to be initiated through the patient's pharmacy. Leaving messages at our office for refill requests will only delay the process of receiving your medications. The only exception concerns certain medications that require a written prescription and cannot be called in to the pharmacy (these include stimulant medications for the treatment of ADHD).

I am responsible for complying with my medications. I understand that I will not make any abrupt changes in my medications without first consulting with my physician. I understand I should not be consuming alcohol or any illicit substance while taking my prescribed medications. It is the patient's responsibility to inform the physician of all other medications that other doctor's may be prescribing to me. It is the patient's responsibility to check on supply of medications and refills prior to their appointment. The patient is responsible for requesting a medication refill at least 5 days before running out of medications. I understand that under NO circumstances will medications be filled after hours, on weekends, or holidays. I understand that in the event of a missed, rescheduled, or cancelled appointment, my medications may not be refilled.

AFTER HOURS: I understand that calling the office after regular business hours, weekends, or holidays will provide me information on how to contact the on-call physician. I understand that this may not be my own psychiatrist. I understand that this service should only be utilized for urgent matters that cannot wait until the next business day. Calls placed for non-emergent issues such as medication refills, scheduling or billing issues, will result in being charged for that call.

EMERGENCIES: I agree to contact the River City Psychiatry, LLC, on-call psychiatrist, which may or may not be my psychiatrist, immediately regarding any urgent medical/psychiatric issues, including significant side-effects of medication and any significant changes in mood/behavior. However, if my situation becomes physically unsafe – whether due to a medical emergency such as loss of consciousness, possible overdose, etc., or due to dangerous psychiatric symptoms

(including agitation, threats of suicide or violence), I will immediately call 911 directly or proceed to the nearest emergency room if able to do so safely, so that those trained personnel can provide immediate professional emergency services. If I am unable to reach my psychiatrist, I will call 911 or proceed directly to the nearest emergency room. If I am a patient that requires frequent crisis management, or has a history of requiring this, I realize I may be better served by a more comprehensive agency that can better address these ongoing issues.

NON-EMERCENCY CONTACT: If I need to contact any of the staff of River City Psychiatry, LLC, for non-urgent matters, I can call during regular business hours. I understand that every effort will be made by the staff to return my call within 2 business days. I am responsible for leaving a message that includes my name and date of birth, explains the nature of the call, and includes information on how to be contacted such as a return phone number. Be aware that messages asking simply to "speak with the doctor", with no other information provided, may not be returned as quickly as a message for a patient stating specific issues they are having, such as medication side effects or change in mood/ behaviors. I will allow my psychiatrist or designated representative to leave messages on my answering machine/voicemail unless I specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality. I understand that most significant medical or psychiatric questions will need a face-to-face appointment to properly evaluate the situation.

PHYSICIAN ABSENCE: I understand that if I have an emergency while my psychiatrist is on leave, that another psychiatrist in River City Psychiatry, LLC, may provide covering services. This psychiatrist will have access to my confidential medical information during this time.

EMAIL: I understand that email is not a confidential means of communication. I will call the office whenever communication is necessary. I understand that River City Psychiatry, LLC, cannot ensure email messages will be received and responded to in a timely fashion. I understand email is not the appropriate way to handle confidential information or emergencies.

PRIVACY PRACTICES: I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PHOTOCOPIES: I hereby authorize photocopies and electronic copies of this form to be as valid as the original.

The invalidity of any provision of this agreement will not affect the validity of any other provision.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The confidentiality of your personal health information is very important to us. Your medical record, generally containing information your symptoms, test results, diagnoses, and treatment, serves as a basis for planning your future care and treatment. We use this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal provider or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of your privacy rights and of legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this notice but reserve the right to change the terms of this notice. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. You may request a copy of our Privacy Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death, or necessary to prevent or lessen a serious and imminent threat to the health or safety of any person or the public. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up certain forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information (when we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we disclosed information for reasons *other than* treatment, payment or healthcare operations. We have 60 days to respond to your written request. If we do not act on your request within the 60 days, we will notify you that we are extending the response time by 30 days. If we do that we will explain the delay in writing and give you a new date of when to expect a response.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergencies. Requests for further restricted access to your health care information must be submitted in writing.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information above. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request. We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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SIGNATURE PAGE

I have read both pages of "Policies and Procedures" carefully before signing. I agree to abide by the policies as explained. This also serves as my consent for treatment as described in this policy. I understand that submitting information to River City Psychiatry does not establish a physician-patient relationship with any of its psychiatrists.

Patient's Name _____ Date of Birth _____

Patient's Signature _____ Date _____

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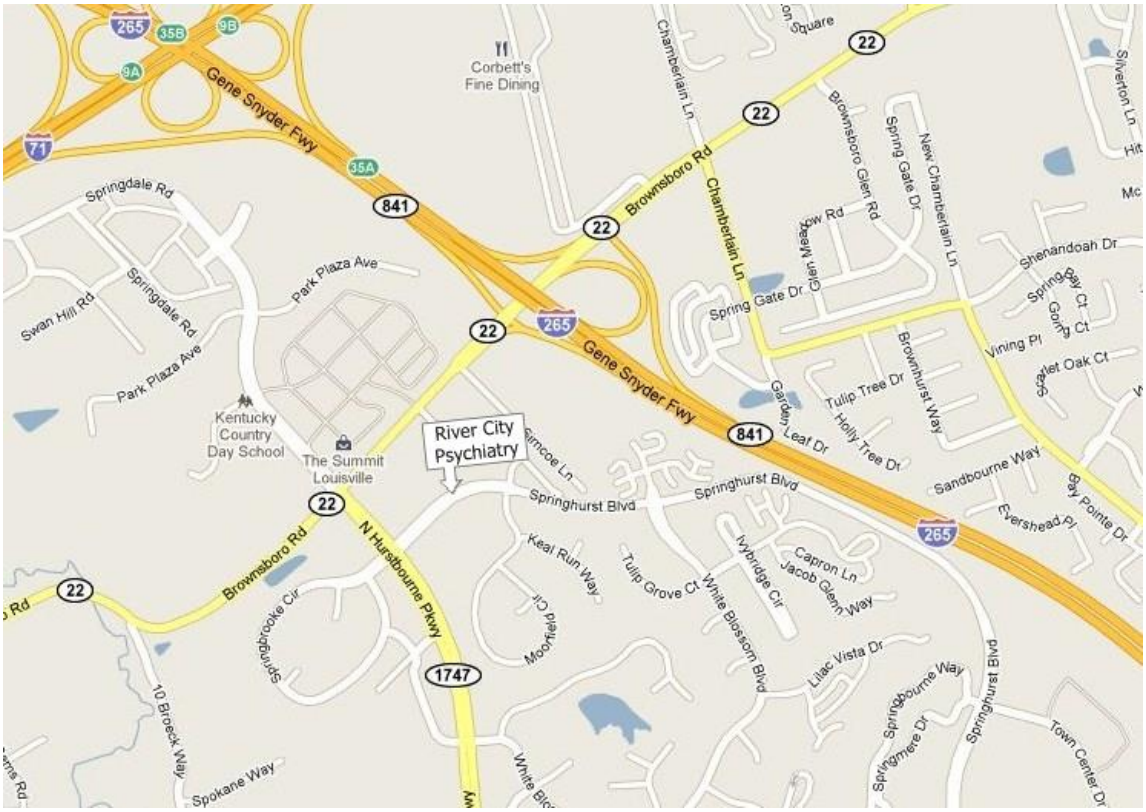
By my signature below I acknowledge receipt of the Notice of Privacy Practices

Patient's Name _____ Date of Birth _____

Patient's Signature _____ Date _____

An electronic copy of this form will be retained in your medical record.



******GPS/online maps may lead you to an inaccurate location, so please use one of the following for accurate driving directions.******

RIVER CITY PSYCHIATRY
4201 Springhurst Blvd, Ste. 203
Louisville, KY 40241
(502) 425-6690

From downtown Louisville or Southern Indiana: Take I-71 N to Gene Snyder/265 S. Take your first exit onto Brownsboro Rd/US 22 and turn right off the exit. At the 2nd light, turn left onto Hurstbourne Pkwy. Take your first left onto Springhurst Blvd. The entrance to our office park will be your 2nd left. You will enter between the buildings with addresses 4211 and 4205.

From Watterson Expressway/I-264: Take Watterson Expressway/264 to I-71 N. Follow I-71 to Gene Snyder/265 S. Take your first exit onto Brownsboro Rd/US 22 and turn right off the exit. At the 2nd light, turn left onto Hurstbourne Pkwy. Take your first left onto Springhurst Blvd. The entrance to our office park will be your 2nd left. You will enter between the buildings with addresses 4211 and 4205.

From the Northeast/I-71: Take I-71 S to Gene Snyder/265 S. Take your first exit onto Brownsboro Rd/US 22 and turn right off the exit. At the 2nd light, turn left onto Hurstbourne Pkwy. Take your first left onto Springhurst Blvd. The entrance to our office will be your 2nd left. You will enter between the buildings with addresses 4211 and 4205.

From the South/I-65: Take I-65 to Gene Synder/265 E. Take exit 32 to Westport Road. At the end of the exit, turn right on to Westsport Road. Turn right onto Springhurst Blvd. Follow approximately 1.5 miles and then turn right into our office park. You will enter between the buildings with addresses 4211 and 4205.

From the East/I-64: Take I-64 to Gene Snyder/265 N. Take exit 32 to Westport Road. At the end of the exit, turn right on to Westsport Road. Turn right onto Springhurst Blvd. Follow approximately 1.5 miles and then turn right our office park. You will enter between the buildings with addresses 4211 and 4205.