

## POLICIES AND PROCEDURES

**CONSENT FOR TREATMENT:** I consent to evaluation and medically necessary treatment by professional staff 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. I understand that River City Psychiatry, LLC will not provide any evaluation for the sole purpose of seeking medical or mental disability, and I must find another professional to assist me in this purpose. I understand my psychiatrist does not determine when I am able to return to employment, if applicable.

**ASSIGNMENT OF INSURANCE BENEFITS:** I authorize and direct payment of benefits under my medical insurance to River City Psychiatry, LLC or its designated professional staff. If my insurance information changes, I will notify River City Psychiatry, LLC immediately. If I should desire to not use my insurance benefits, payment must be made in full at the time of each visit. If I should reach my maximum level of insurance reimbursable services, further services must be paid on the date of service. If at any time my insurance company disputes a filed claim, it is my responsibility to contact the insurance and provide assistance in resolving any dispute. Failure to do so in a timely manner may result in extra charges for which I will be responsible.

**FEES FOR SERVICES:** I understand that the out-of-pocket fees for the basic services provided by River City Psychiatry, LLC, are as follows, and additional services/fees must be discussed with my psychiatrist:

Initial Diagnostic Evaluation, 50 minutes duration	\$220-\$250/ session
Therapy, 40-50 minutes duration	\$175-\$200/session
Medication Management, 20-30 minutes duration	\$125/session
Medication Management, 15-20 minutes duration	\$85/session

**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. If I am covered by an insurance company with which my psychiatrist has a binding contract, I am required to pay any copayments and coinsurance dictated by insurance company. I understand there are certain services that may not be covered under insurance and I will personally be responsible for these charges. These include but are not limited to paying for my psychiatrist's involvement in depositions, court appearances, and contact with attorneys. I agree to pay for charges related to record retrieval, copying costs, and statement of opinion when I authorize release of my records to any outside party. I fully understand that I will be personally responsible for these charges even if my medical insurance company does not pay, and my psychiatrist reserves the right to charge a minimum of \$50 for these services. In the event of default I promise to pay such collection costs and attorney fees as may be required to effect collection of the indebtedness. I understand that my psychiatrist reserves the right to charge for phone calls based on the time spent per call and that I am responsible for these charges. I understand there will be a \$50 charge for returned checks.

**CANCELLATIONS:** I understand that when I schedule an appointment, this time is specifically allocated for me. 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 2 PM if my appointment is Monday at 2 PM). If a cancellation is not made within that time or is missed without notification, I may be charged the full price for the appointment. I understand that the full price of the appointment is not the same as the insurance copay (see fees above). I understand that my insurance companies will not provide reimbursement for missed/cancelled appointments. I understand that repeated late cancellation of appointments and/or failure to keep scheduled appointments may make it impossible for my psychiatrist to continue seeing me.

**MEDICATIONS:** I am responsible for complying with my medications. I will make sure that I have an adequate supply of medication(s) until my next appointment. I understand that under NO circumstances will medications be filled after hours, on weekends, or holidays. I understand that if I need a medication refilled before my next visit, I will have my pharmacy fax a refill request to River City Psychiatry, LLC, and that I can expect it to be addressed within 2 business days. I understand that in the event of a missed, rescheduled, or cancelled appointment, my medications may not be refilled. Prescriptions for controlled substance refills will always require an appointment with my psychiatrist.

**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.

**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 unexplained or excessive bleeding, 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.

**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 1 business day. 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. 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:** Some of the professionals at River City Psychiatry, LLC, may chose to communicate with me via email. If I choose to communicate in this manner, I understand that email is not a confidential means of communication. Although email will be checked on a regular basis, 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 below.

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 complaint 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.

### **HOW TO CONTACT US**

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