MIDTOWN PSYCHIATRY AND TMS CENTER, PPLC

DANIELA M. WHITE, MD

www.midtownpsychiatrytms.com

MPTC FINANCIAL POLICY

MPTC is committed to providing you with quality care. To assist us in establishing your financial account, please supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information. Bring your insurance card at each visit. Inform us 2 days in advance of your appointment if there have been any changes in your insurance coverage. Satisfy all insurance co-payments, deductibles and non-covered services on the day your services are rendered. Authorize release of information necessary for insurance filing and pre-certification (sign below)

REGARDING DIVORCE: MPTC, Dr. White, her associates or staff do not get involved in disputes between divorced parents regarding financial responsibility for the child's medical expense, please bring proof of guardianship. By signing as guarantor below, you agree to be financially responsible for the care provided to your child, regardless of whether a divorce decreed or other arrangement placed obligation on your former spouse.

TELE-PSYCHIATRY: In order to prevent interruption of care in case of your travel or temporarily living away for school or work, this office provides Skype sessions. Skype provides the encryption necessary to protect the privacy of the conversations. By signing below, you agree to insure the privacy of the conversation at your location during the Skype session. Payments are due at the time of the service through credit card or a check mailed in advance.

REGARDING INSURANCE: Full payment is required at the time of service. We will supply a copy of your statement, so you can file for reimbursement from your insurance provider if we are an out of network provider. We will not file any secondary insurance. Insurance is a contract between you and your company. We will not become involved in disputed between you and your insurance company regarding deductibles, co-insurance, coordination of benefits, pre-existing conditions. You are responsible for the timely payment of your account. Please note that co-payments and/or deductibles will be collected at the time of service form all patients.

Dr. White is not a Medicare provider we will not nor, can you independently file a Medicare or a secondary insurance claim for the charges incurred. Initial that you understand this statement_____

- I have read and understand that I am personally responsible for payment on this account
- I authorize payment directly to Dr. White or MPTC, PLLC. Any changes in this authorization must be received in writing within 30 days of the effective date.
- I agree to release of any and all medical and financial information necessary to process this and future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within 30 days of effective date.
- I authorize Dr. White to give reasonable and proper medical care by today's standards.

Fees NOT covered by Insurance:

_____Missed or cancelled appointments: Patients will be billed for any appointments not cancelled 24 hours in advance. Our office provides appointment reminders as a courtesy service, but the reminder cannot be relied upon on. It is the patient's responsibility to know when his or her appointment is. 1st missed appointment 50% of full fee, 2nd missed appointment 100% of full fee, 3rd missed appointment paid for or an accumulated balance of $300 will end our patient-doctor relationship.

_____Prescription Coverage: Pharmacy benefits vary greatly from one plan to the next. Dr. White understands insurance restrictions and attempts to prescribe in a manner which is mutually agreeable to both her patients and insurances carriers. However, she cannot predict how any specific medication will be covered by your plan. It is the patient's responsibility to know at the time of his or her visit, what medications your insurance will cover. There will be a charge for Prior Authorization requests completed by MPTC of $15.

_____Triplicate Prescription (Controlled Substances): Triplicate prescriptions should be obtained during scheduled medication monitoring appointments. There will be a $15 charge to process refill requests outside of appointments and $25 for a lost or misplaced prescription for medications that require triplicate prescriptions, such as Adderall, Daytrana, Dexedrine, Metadate, Ritalin, Vyvanse and other schedule 2 prescriptions. Refills WILL NOT BE GRANTED to patients not seen for an appointment in greater than 3 months. Request should be emailed to info@midtownpsychiatrytms.com three (3) working days (72 hours) in advance (Monday-Thursday 8 am to 5pm). Note that these prescriptions expire in 21 days

_____Non-Triplicate Prescriptions: Prescriptions are usually written during scheduled appointments. Refills are given to last until next scheduled appointment. Refills WILL NOT BE GRANTED to patients not seen for an appointment in greater than 4 months, 3 months for controlled substances. If you have missed an appointment or do not have enough medication to last until your next appointment, request routine refills should be handled by sending an email to info@midtownpsychiatrytms.com during working hours (8 am to 5 pm) or by calling your pharmacy and having them fax/escribe a request to the office. Allow three (3) working days (72 hours) for these refills to be processed. $15

_____Emergency Refill Requests: Request for medications to be refilled in a 24 hour time frame or in an emergency (i.e. after 5pm, weekends, holidays) will be honored. You will be assessed a charge for the physician's time to answer your call, review the chart, document the appropriateness of the refill, call in the prescription. $75

_____Forms and Letter: Patients frequently request letters for school, work, special accommodation, legal matter and certain types of disability during medication monitoring appointments. Please keep in mind that your medication appointment is scheduled for the purpose of assessing your progress in treatment and response to medication. If time permits, brief forms requiring less than five minutes maybe completes in your allotted appointment time. Your fee will be determined by the length of time and level of complexity required to complete this service. Simple (5 min or less) - $30; Moderate (10 to 15 min) -$50; Lengthy (20 to 30 min) -$75; Complex (30 to 60+min) -$300/hr

Guarantor Signature_____Date_____

Print Name_____Relationship to Patient_____

PATIENT NAME_____Date of Birth_____

PATIENT INFORMATION

Date_____ **Referred by**_____

Last Name_____First Name_____MI _____

Patient's Address_____
(Street) (City). (State). (Zip)

Home #_____Cell # _____Work #_____

Current Physician_____ Physician Number _____

Previous Psychiatrist/Nurse Practitioner _____

_____
(Address and Phone Number)

For Minor Patient

Mother's Last Name_____First Name_____DOB_____

Father's Last Name_____First Name_____DOB_____

Who does the child live with_____Address_____

Legal Guardian_____Guardian's Address_____
(if different then a parent)

_____
(Please provide a copy of the court possession order)
Patient Name_____DOB_____

Policy Holder's Name_____DOB_____

Policy Holder's Employer_____Insurance Company_____Policy Number_____

Group Number_____Benefits #_____Pre-Cert #_____

Gender: F___M___SSN_____ TDL_____

Relationship to insured: Self_____Spouse_____Child_____Other_____

____ I have no insurance coverage under any other group health plan (please initial)

____ I have secondary coverage as follows:

Policy Holder's Name_____DOB_____

Policy Holder's Insurance Company_____Policy #_____Group#_____

Gender:F____M____SSN_____Relationship to Insured: Self____Spouse_____Child_____Other___

_____ _____
Signature of Patient or Patient's Guardian Date

_____ _____
Print Name of Patient or Patient's Guardian Date

MIDTOWN PSYCHIATRY AND TMS CENTER
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Houston, TX 77007
713.426.3100 (P)
713.426.3102 (F)

POLICY REGARDING URINE DRUG SCREENING

With the increased concern of the misuse and distribution of prescribed medication and/or concomitant use of illicit drugs, it became a good practice of medicine that a urine drug screen (UDS) be done for:

1. All new patients who present with psychiatric complaints, since a multitude of prescribed medication and/or illicit or recreational substances (marijuana or alcohol) can mimic presentation such as anxiety disorder, affective disorder, ADHD, etc;
2. New and established patients that will be prescribed controlled drugs such as stimulants and benzodiazepines (i.e. Adderall, Ritalin, Klonopin, Xanax etc); random UDS will be performed during the treatment as well;
3. Reports of lost or stolen controlled medication.
4. Notification from the pharmacy of attempts at early refills of controlled medications or reports that more than one provider is writing controlled medications.

I, _____ understand this policy and further understand that due to the safety and professional liability that accompanies prescribing such controlled medications as stimulants and benzodiazepines, patient's not willing to comply with this policy will not receive these medications.

The UDS is an extensive qualitative and quantitative test that checks for a large variety of prescribed, recreational or illicit substances. Your insurance company will pay **LabCorp** directly, unless there is a balance that you might be responsible for. For any billing concerns and questions, please contact **LabCorp** Patient Billing Customer Service at 800-845-6167. In the event that you chose to use a provider other than **LabCorp**, please provide us with the copy of the results within a week of the request, to avoid interruption of treatment.

_____

Patient (or Parent) Signature Date

_____

Witness Date

Midtown Psychiatry and TMS Center

Patient Acknowledgment of Receipt of Privacy Practices Notice

I _____, hereby acknowledge that I have reviewed and received a copy of this Office's Notice of Privacy Practices explaining:

How this office will use and disclose my protected health information
My privacy rights with regard to my protected health information
This offices's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy upon request.

I also understand that if I have any question or complains, I may contact:

Office for Civil Rights
1301 Young Street, Suite 1169
Dallas, Texas 75202

You may also contact the secretary of the US Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient ot Personal Representative

_____ _____

Patient Signature Date

_____ _____

Patient Print Name Relationship to Patient

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of receipt of our Notice of Privacy Practice. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons

- ☐ Patient refused to sign (date) _____
- ☐ Communication barriers prohibited obtaining an acknowledgment
- ☐ An emergency situation prevented us from obtaining an acknowlegment
- ☐ Other

Attempt was made by: _____

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LEGAL FEES

MPTC is committed to provide a high quality of care to its patients, including good customer care, therefore striving to diminish the number of rescheduled appointments due to doctor's changes of schedule, the waiting time before the actual doctor appointment and the waiting time for the returned phone calls etc.

Dr. White's practice is entirely outpatient based, therefore any added legal responsibility takes away from the direct clinical care and involves a disruption of schedule, sometimes requiring rescheduling of patients, additional staff time, including working weekends (doctor and staff) to accommodate the care of acutely ill patients that have been rescheduled etc.

The hourly charged fee for any legal matters is $ 500 per hour. The hourly rate is charged for transportation time, the time used to review documentation and/or preparing letters requested for legal reasons, testifying, waiting to testify, etc.

In addition there are minimum fees as follows (hourly rate billed against minimum, but no refunds if not fully used):

1. **Preparation of letters/reports**: minimum $ 750
2. **Chart review**: minimum $ 1000
3. **Subpoena** as a treating physician or expert witness : half day 5 hours equal to $ 2500 full day equal to $ 5000.Every additional day required in court will incur a proportional increase in fee.
4. **Consultation with attorney:** starting at 30 minutes will equal $ 250 consultation fee; additional time will incur a proportionate increase in charge; similar rate will apply for phone conversations, etc

All fees are to be paid in advance. Subpoena requires advance notice of two weeks and a retainer according to the estimated time required in court.

Guarantor Name_____Date_____

Print Name_____Relationship to Patient_____

PATIENT NAME_____Date of Birth_____

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Authorization for Release of Medical Information from Medical Records

Patient Name_____DOB_____

Date Requested_____(valid for 365 days unless otherwise specified)

I hereby authorize Daniela M. White, MD or MPTC, PLLC to release or obtain (please circle one or both)

Information to or from (please circle one or both) _____
(Name or Person/Physician)

_____
(Address or Phone Number or Both)

Information from Medical Records should include

Complete/Part of Medical Record	_____	Medical History and Physical Exam	_____
Psychological Report	_____	Psychiatric Assessment	_____
Medical History and Physical Exam	_____	Laboratory Reports	_____
Verbal Communication Only	_____	Other	_____

I understand and agree that the information I am authorizing to release may include mental health information, HIV test results, diagnosis, drug test results, treatment and related information.

I further understand that I may cancel this authorization at any time by notifying the office in writing, except for the action that been taken in reliance on it. Unless earlier revocation, this authorization automatically expires in 365 days after the date of request unless another date, event or condition specified.

To the Party Receiving this information:
This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulation (42 CFR part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains.

I release and agree to hold Dr. Daniela M. White, MD or MPTC, PLLC employees and representatives harmless from all liability associated with the authorized release of my patient confidential information. I understand that Dr. White or MPTC, PLLC cannot be responsible for the use of redisclosure by a third party

_____	_____
Patient/Guardian Signature	Witness
_____	_____
Print Name	Print Name
_____	_____
Date	Date