

# Jason James, M.D., PLLC

## Agreement and Consent for Psychiatric Services and Consultation

The following is an agreement entered into between Jason James, M.D., PLLC and

\_\_\_\_\_ (as patient).

The modalities of outpatient psychiatric treatment that are utilized in this office are established upon evidenced-based standards of care. However, as with all forms of clinical treatment, there are risks to be considered in the process of making an informed decision. This form is designed to inform you of these risks as well as the potential benefits of treatment, and to discuss the general policies and procedures of our office.

### Overview of Clinical Services

Jason James, M.D., PLLC uses a variety of outpatient treatment modalities, including individual psychotherapy and medication management. Treatment approaches are based upon each patient's specific clinical needs as identified during the initial session(s). The patient's treatment options are then discussed and a plan of medical care is determined. Often, psychotherapy may be all that is required, but in other cases a combination of medications and psychotherapy may be indicated in a client's treatment plan.

If clients are receiving psychotherapy services from another provider and they are referred for or seeking medication management services from Jason James, M.D., PLLC, then every effort will be made to coordinate care with the clinician who is providing therapy.

A patient's needs sometimes change over the course of their outpatient treatment, which may necessitate a reevaluation of their treatment plan. When this occurs, treatment options are once again discussed and a clinical course is determined by the patient and psychiatrist. If at any time the patient and/or psychiatrist believe that the patient's clinical issues require alternative or additional resources, an effort will be made to assist the patient in locating these resources. The patient at any time may end treatment with Jason James, M.D., PLLC, and the only tasks the patient will be responsible for are notifying Jason James, M.D., PLLC and paying for services that have been already received. Jason James, M.D., PLLC has the ability to also terminate treatment at its own discretion. If this occurs and further treatment is needed, then the office will assist the patient in obtaining other referrals.

### Benefits and Risks of Treatment

The benefits of outpatient psychotherapy may include improved functioning in your personal and professional relationships, improved communication skills and a reduction in the symptoms that led you to seek therapy in the first place. The risks or potential side effects of participating in psychotherapy may, at times, include increased levels of stress and anxiety, escalation of undesired behaviors, relationship disruption and emotional reactivity.

Psychiatric medications have specific indications for a variety of psychiatric symptoms and illnesses. If a medication is indicated in the patient's treatment, then the specific benefits and risks will be discussed, so that the patient is able to provide an informed consent to treatment with the medication.

Initial \_\_\_\_\_

# Jason James, M.D., PLLC

## Office Policies

1. A patient's private clinical records are maintained exclusively by Jason James, M.D., PLLC in a HIPPA compliant system.
2. Payment is due at the time of service. Jason James, M.D., PLLC does not file insurance claims, but a statement can be provided upon request. Most insurance plans require a diagnosis as part of filing a claim. This diagnosis will be discussed with the client prior to providing a statement.
3. Cancellation of an appointment requires at least 24 hours of advanced notice. If sufficient notice is not received, then the client will be charged for the missed session. Emergency circumstances (i.e., hospitalization, accident, a death in the family) are addressed on an individual basis.
4. Fees for medication management and psychotherapy are based on the established rates that are printed on the Fee Agreement Form. Additional information specific to fees and payment is further delineated in the Fee Agreement Form that has been provided and agreed upon by you (the patient).
5. Jason James, M.D, PLLC's telephones are staffed 9:00 AM – 5:00 PM, Monday through Friday. At times Jason James, M.D, PLLC may not be immediately available by telephone and the extension will be answered by a voicemail system. On the message, please leave times and phone numbers for Jason James, M.D., PLLC to reach you and we will attempt to return your call within 24 hours, with the exception of weekends and holidays. **If you are unable to reach Jason James, M.D., PLLC and you cannot wait for a return call, then contact 911 or go to the nearest emergency room.** In the event of an extended absence, information will be provided regarding the availability of a psychiatrist on call. Please note: Text messages and emails are not a secure means of communication with regards to privacy and confidentiality.

## Confidentiality

Information shared with a psychiatrist is held in confidence. In most situations a signed and dated Release of Information (which clearly defines the nature of information to be shared, to whom and for how long) is required as consent to disclose confidential information.

## Limitations to Confidentiality

The law protects the relationship between a client and a psychiatrist, and information cannot be disclosed without written permission. However, there are exceptions. These exceptions include:

1. Suspected child abuse or dependent adult or elder abuse, for which am required by law to report this to the appropriate authorities immediately.
  2. If a client is threatening serious bodily harm to another person/s, I am required by law to report this to the appropriate authorities immediately.
  3. If a client intends to harm himself or herself, I will make every effort to enlist their cooperation in insuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law in order to ensure their safety.
- Further information regarding patient privacy and confidentiality is included in the Notice of Privacy Practices that you have been provided.

Initial \_\_\_\_\_

# Jason James, M.D., PLLC

## Complaints

Complaints against this physician can be made by contacting the:

Texas Medical Board  
P.O. Box 2018  
Austin, TX 78768-2018  
1-800-201-9353

By signing this document I acknowledge informed consent in my decision to seek outpatient psychiatric treatment with Jason James, M.D., PLLC. I have had an opportunity to ask questions and acknowledge that my signature below means that I understand and agree with all of the points above.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

I, Jason James, M.D., PLLC, have discussed the issues above with the patient. My observations of this patient's behavior and responses give me no reason, in my professional judgment, to believe that this person does not have the capacity to give informed and willing consent.

\_\_\_\_\_  
Jason James, M.D.

\_\_\_\_\_  
Date

Copy accepted by Patient

Copy kept by Psychiatrist

# Jason James, M.D., PLLC

## FEE AGREEMENT FOR PSYCHIATRIC SERVICES

### **Standard Fee Schedule**

New Patient Initial Diagnostic Assessment <i>(90 minutes)</i>	<b>\$300</b>
Established Patient Appointments Psychotherapy and Medication Management <i>(60 minutes)</i>	<b>\$225</b>
Medication Management Only <i>(30 minutes)</i>	<b>\$150</b>

I understand and agree to the standard fee for services as listed above. \_\_\_\_\_ (Initials)

### **PAYMENT AGREEMENT**

I understand that I will pay for all services provided either for myself or for my designee,

\_\_\_\_\_ (name), \_\_\_\_\_ (relationship), at the time each session is rendered.

I understand that I may pay with cash, personal checks, money orders, or credit card, however, should my personal check be returned due to insufficient funds, I will be assessed a \$25.00 service charge. I realize that while my signature does not bind me to treatment, it does make me responsible for all charges incurred prior to my termination.

### **MISSED SESSION POLICY**

I understand that unless otherwise indicated, I will be charged my full fee for any missed sessions or sessions cancelled with less than 24 hours notice. Emergency circumstances (i.e., hospitalization, accident, a death in the family) are addressed on an individual basis.

### **USING INSURANCE OR THIRD PARTY PAYMENT SOURCES**

I understand that this contract will supersede any previous contracts that an individual provider within Jason James, M.D., PLLC may have had in the past or currently has with an insurance provider. Furthermore, Jason James, M.D., PLLC does not belong to any insurance panels and therefore it is not a preferred provider for any insurance companies or beholden to their policies.

If I wish to use an out-of-network insurance plan, EAP program, Health Savings Account, or other such third party payer, I understand that Jason James, M.D., PLLC will not file these claims on my behalf. However, I will still be able to request an invoice for the services I have received and the payments I have made so that I may submit these to my insurance company for reimbursement.

If I should choose to use a third party payment source, I understand that I am still responsible for direct payment to Jason James, M.D., PLLC and that I may not receive reimbursement by the third party payment source.

## Jason James, M.D., PLLC

I understand that if I use insurance or another type of third party payment source that I authorize Jason James, M.D., PLLC to release and/or exchange any pertinent information with such entities in order to utilize these benefits. This information includes but is not limited to my presence in treatment, my progress in treatment, my psychiatric diagnosis, any assessment information, and my discharge plan. I understand that most third party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

**I have read the preceding information and I agree to the aforementioned terms.**

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Patient's Name (Print)

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Responsible Party's Name (Print)

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Responsible Party's Signature

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Date

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

# Jason James, M.D., PLLC

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of January 24, 2015 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

## Jason James, M.D., PLLC

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

### Practice Compliance Officer

Priya James

4306 Yoakum Boulevard Suite 345

Houston, Texas 77006

Direct: 713.489.9142



Jason James, M.D., PLLC

# Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Jason James, M.D., PLLC and I hereby acknowledge receipt of its Notice of Privacy Practices.

Name [please print]: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

I am a parent or legal guardian of \_\_\_\_\_ [patient name]. I hereby acknowledge receipt of Jason James, M.D., PLLC's Notice of Privacy Practices with respect to the patient.

Name [please print]: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Revised: 8/19/15