PRACTICE POLICIES

Oleksandr Osipchuk MD, PhD, Psychiatric Services, LLC (The Practice)

OFFICE HOURS:

Regular office hours are Monday noon-5pm Tuesday - Thursday 9am-5pm. Appointments for early morning/late evening hours may be arranged upon mutual agreement and at the doctor's discretion. Scheduling appointment beforehand is required.

THIRD PARTY PAYER (*INSURANCE*):

The third party payer refers to any insurance policy, Medicare, Worker's Compensation, no fault insurance, managed care, or other payment for evaluation and/or treatment services other than private or direct pay (cash or credit card) to which patient may be entitled.

FEES AND CHARGES:

Unless otherwise stated the fees and charges for evaluation and/or treatment services are for clinician's and associate's/employee's time and for any material used. The obligation to pay said fees and charges is not contingent on any specific benefit or result.

All payments (co-pays, coinsurance or deductibles for insured and full costs of visit for uninsured) are due at the time of service.

Please be aware that some insurance plans the Practice does not participate with may reimburse a portion of our fee but usually does not reimburse no show/late cancelation fees. It is your responsibility to file insurance claims for insurance plans the practice does not accept – the Practice will not provide this assistance.

Services may be declined if no form of payment is brought to the appointment. No appointments will be made for clients with balances that are 30 days past due. Please see Financial Policy.

It is your responsibility to provide a copy of your insurance card, photo ID for patient and to update our office if your insurance changes. It is your responsibility to know your own benefits and eligibility. We also will verify your benefits and eligibility and inform you of your expected co-pay and any service limits defined by your individual policy. You are responsible for fees for any visit or service not verified, not covered, or denied by your insurance company.

Any unpaid balance may be reported to an attorney, collection agency, or credit bureau.

APPOINTMENTS AND CANCELLATIONS:

By scheduling appointments you accept financial responsibilities for the office time assigned to you. You agree to pay full a "No Show Fee" of $100 for any appointment canceled less than 24 hours prior to scheduled time. Cancelation of Monday appointments must be arranged by the scheduled time on previous Friday. There will be no exceptions without documentation of an emergency that occurred within 24 hours prior to scheduled appointment.

Appointment reminders are provided only by phone call or email by your signed authorization and are a courtesy service. Failure to receive an appointment reminder is not an exception to the no show and cancellation policy.

We ask you to arrive for your appointment 10 minutes early to complete any required documentation. If you arrive 5 minutes late for a 15 minute appointment, there is no guarantee that you will be seen this day and rescheduling may be required. If your provider has to cancel and reschedule your appointment, you will be provided with appointment day and time and the Practice will ensure you are prescribed enough medication to last until your new appointment.

PHONE CALLS/EMAIL CONTACT:

If require to speak to a clinician, please leave a message providing all pertinent information, including patient's name, caller's name, concern and contact number(s) so that your provider can address your call as efficiently as possible. Your provider will contact you within 24 hours, during regular business hours. Messages received after close of business Friday will be returned the following Monday. Calls that require an excess of 5 minutes for your provider to address are subject to charges. Calls may be recorded.

Provider may decline to provide such services outside of face-to-face visit at regular hours.

If you experience medical and/or psychiatric emergency do following: Proceed to the nearest Emergency Room (ER) or call 911 (or crisis number 1-800-704-2651) and ask the ER to inform our office about nature of your emergency.

Your provider may agree to maintain e-mail contact with you on case-by-case basis. HOWEVER, DO NOT CONTACT YOUR PROVIDER BY EMAIL IN THE CASE OF AN EMERGENCY.

Your provider will respond to your email within 5-7 days and may decline to provide such services outside of face-to-face visit at regular hours.

Phone and e-mail communications may incur charges depending on the length of time the response requires.

EMERGENCY:

If you experience medical and/or psychiatric emergency do following:

Proceed to the nearest Emergency Room (ER) or call 911 (or Crisis number 1-800-704-2651) and ask the ER to inform our office of the nature of your emergency.

AFTER HOURS, WEEKEND AND HOLIDAY CALLS:

Double charges are due for all non-emergency services provided after hours (example: request medication refill, completion of forms etc.). Provider may decline to provide such services outside of face-to-face visit at regular hours. Messages left after hours concerning problems that can be addressed during regular business hours will not incur this additional charge.

ACCESS TO THE RECORDS, CONFIDENTIALITY, THIRD PARTY PAYERS AND OTHER PROVIDERS:

When you or other family member signed up with a third party payer, the agreement with third party payer may have permitted such payer to have access to the patient records at any time and the Practice has no control over this access. The Practice has made no representation as to whether the third party payer is required to keep the information in such records confidential. Practice has no control over what happens to information released to third party payers, and you agree to hold the Practice harmless in releasing information to the patient's third party payer or in allowing access to the records as may be required by the patient's third party payer.

If you need your provider to discuss treatment information with other providers, a current Release of Information form is required.

PRESCRIPTIONS/REFILLS:

The Practice will provide you with prescriptions for medication until your next visit. Unless you are on a controlled substance psychotropic medication, all prescriptions are submitted electronically to your pharmacy. Federal law requires that no prescriptions for controlled substances can be submitted electronically or by phone call. For controlled substance, a face-to-face visit is required at least once a month.

If you failed to book a timely appointment or keep an appointment and request known non-controlled medication refill, you will be charged for this service. Refills will only be approved for current patients who have scheduled follow-up appointments.

The Practice does not provide medication changes made over the phone as this generally requires thorough re-evaluation and discussion. If you require a change to your medication regimen, you are required to schedule an appointment.

AGREEMENTS / ACKNOWLEDGEMENTS / DISCLOSURES:

1. I understand that initial evaluation/consultation provided by the Practice does not constitute establishment of patient-doctor relationship. Patient-doctor relationship is considered established only after consent to treat is signed by both parties.

2. I agree to consistently attend scheduled appointments at a minimum of once every 3 months (for controlled substances minimum is once a month). If for any reason I have not been seen in 3 months (1 month for controlled substances) I will be dismissed from the Practice and my current case will be closed. If I decide to renew my treatment with the Practice, it will require another initial evaluation appointment. I will be responsible for the full initial evaluation fee for this appointment, which is usually not covered or reimbursed by insurance policies.

3. It is my responsibility to inform the Practice about changes to my insurance plan in timely manner.

4. I agree to pay for the cost of an attorney, collection agency or credit bureau reporting when such services initiated by the Practice for the purposes of facilitating collection of my past due balance are required. Further, I authorize and give consent to the Practice to release to the attorney, collection agency and/or credit bureau any necessary demographic information about myself and the patient, including that the patient received psychological evaluation and/or treatment services, but excluding specific clinical information

5. As a mutual agreement between me and treatment provider, we both reserve rights to discontinue relationship without cause with 30 days notice. I will be provided list of mental health professionals and agree to arrange following treatment on my own. The Practice will provide me with services in case of a psychiatric emergency for a period of 30 days. If I fail to comply with requirements of the Practice, I agree to be dismissed from the Practice without my consent. Failure to comply as such will start count of 30 days emergency coverage. Dismissal without consent does not obligate the Practice to provide medication during this 30 day period.

Practice requirements are (but not limited to):

- I will take medication as prescribed.
- I will be compliant with treatment recommendations (psychotherapy, EKG, lab testing, other providers' evaluations and consults, discontinuing use illicit substances, etc.).
- I will be monitored frequently for response to newly initiated medication (some treatment modalities will require weekly appointments and/or lab checks).
- I will be honest with Provider about all subjects related to my treatment.

6. I understand that the Practice does not prescribe narcotic pain medication, does not routinely prescribe controlled substances, and limits use of the highly addictive medication Alprazolam, also known as Xanax.

7. I understand that some psychotropic medications used during pregnancy/lactation may have harmful results on my health and the health of the fetus/child. It is my responsibility to inform the practice promptly about planned or actual pregnancy.

8. I understand that the format and content of the medical record and any of its parts are copyright protected and cannot be used for any reason other than my care. Any exceptions to this will require my written permission to the Practice.

9. I understand that it is my right to request that the Practice has limited access to my medical records from other providers and that I can withdraw permission for the release of my records to the Practice. I understand that this request must be in writing and that limiting or withdrawing my permission may result in the discontinuation of my relationship with Practice. If this occurs, I will need to seek care from another source.

10. I will provide the Practice with my contact information and authorize use of phones, any messaging person or system, voice mail answering machines, faxing, or emails to convey information regarding my care to myself or/and authorized others. I understand that every effort is made to protect my privacy; however no absolute privacy guarantee is given.