

Confluence Psychiatry PLLC

Charles Shuman MD

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Confluencemd.com

303-870-8331

## TREATMENT CONSENT FORM

Please read carefully, initial each page sign and date on the last page.

### SERVICES OFFERED

#### INITIAL EVALUATION

I generally spend 50-60 minutes for the initial evaluation. This assessment focuses on determining the best treatment plan possible and is specific to each individual patient. It is extremely important for this initial assessment to be as comprehensive as possible, therefore, please make sure to complete the intake forms prior to the initial assessment this will insure a more efficient evaluation. If after the initial assessment, we have determined that our services are not the best fit. I will make referrals to other providers that may be a better option for providing treatment. In this case a physician patient treatment relationship will not have been established.

At your initial visit, I will conduct a thorough review of your current complaints and of your background. By the end of the initial visit I will offer my preliminary impressions, and we will discuss your treatment options. Sometimes, psychotherapy or medication alone will suffice. Often, a combination of psychotherapy and medication management is optimal.

#### MEDICATION

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone or when a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs. If it is agreed that medications are indicated, I will discuss with you the medication options that are available to treat your current condition. I will discuss the risks and benefits of the medication options.

Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

#### FEES

For an initial evaluation, my fee is \$320.00. Follow up psychotherapy or combination (psychotherapy and med management) visits will last fifty-minutes and will cost \$280.00. The fee for a 25-minute med management visit is \$160.00. Other miscellaneous services such as filling forms, telephone correspondence, prior authorizations, court hearings, preparation of reports etc. requiring more than ten minutes of time, will cost \$65.00 per ten-minute interval. Fees may be subject to change.

## CANCELLATIONS AND NO-SHOWS

If you must cancel or reschedule an appointment, I require at least 48-hour notice (weekends not included). Cancellations that occur with less than 48-hour notice or failure to show to an appointment will be charged the full fee for the session.

## PAYMENTS

I will expect payment at the time of scheduling or prior to the beginning of an appointment, unless we have agreed on other arrangements. I accept cash and major credit cards. If payment is 60 days past due, I reserve the right to utilize legal resources such as collection agencies or small claims court in order to obtain payment for my services. A credit card will be kept of file and will be charged if payment is not received at the time of service.

## INSURANCE POLICIES

I do not currently accept insurance policies for payment with Confluence Psychiatry PLLC. If you have insurance and if you wish to be reimbursed for your sessions, you will need to consult your insurance company to determine their policies regarding mental health benefits. I will provide you with a receipt that you can submit to your insurance company for reimbursement.

## MEDICAL RECORDS

I am required by law, to keep complete medical records. Most of my medical records are in written form and are kept in a locked office in a secure building. Any electronic records such as prescription records will be stored in secure HIPPA compliant platforms. You are entitled to review your medical record at any time, unless I feel that by viewing your records, your emotional or physical well-being will be jeopardized. If you wish to view your records, I recommend that we review them together to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record may be charged a 20\$ fee. My email service provider is HIPPA compliant.

## CONFIDENTIALITY

The security of your sensitive information is of utmost importance to me, and I am bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent.

Aside from emergency situations, information can only be released about your care with your written permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information (as described above) as a condition of your insurance coverage. Several exceptions to confidentiality do exist that actually require disclosure by law: (1) danger to self – if there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection; (2) danger to others – if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization; (3) grave disability – if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services to provide for your basic needs; (4) suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a

child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency; (5) certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a court order. Although these situations can be rare, we will make every effort to discuss the proceedings accordingly.

#### CONTACT INFORMATION

My phone 303-870-8331 or messaging me through the messaging system on my website [confluencemd.com](http://confluencemd.com) is the best way to contact me outside the office. I am often not immediately available by telephone. If you leave a message on the phone, please state your name clearly, your phone number(s) (even if you think I have it), reason for calling, and let me know when is the best time and method to contact you. For non-urgent matters, please allow 24 business hours for a response. Messages left late in the day, on weekends or holidays, may not be returned until the next business day. If you or someone close to you is in immediate danger, please call 9-1-1 or proceed to the nearest emergency room. If I am unavailable for extended periods of time (i.e., vacation, conferences, etc.), a trusted colleague will provide coverage and contact information will be provided on the office voicemail.

If you choose to contact me via e-mail, please be aware that e-mail is not a secure means of communicating sensitive mental health information, however my email service provider is HIPPA compliant, and meets standards for communication under HIPPA for email providers. E-mail is not an appropriate way of contacting me in an emergency. Please inform me in the comments section below if you want to opt out of email communication.

#### TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of my services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Client's signature: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Charles Shuman MD \_\_\_\_\_ Date: \_\_\_\_\_

Psychiatrist signature: \_\_\_\_\_

Comments: \_\_\_\_\_