CENTRAL ILLINOIS PSYCHIATRIC ASSOCIATES

405 Kays Drive, Suite B, Normal, IL 61761, (309)862-0064

OFFICE POLICIES AND INFORMATION DISCLOSURE STATEMENT

Welcome to Central Illinois Psychiatric Associates. Please read the following information about the psychiatric and psychotherapy services at our office.

Given the therapeutic nature of our services, we do not provide assessments or recommendations in support of legal actions such as:

- Child custody
- Parental fitness
- Competency evaluations
- Lawsuits
- Criminal charges
- Workman's compensation
- Disability determinations

If you require an assessment for such issues, we request that you seek an independent evaluation. Health care provider certifications for FMLA, fit for duty or work release paperwork, or other attestations of medical condition will only be considered for established patients and **will not** be completed during an initial visit.

CONFIDENTIALITY AND CLIENT RIGHTS

Confidentiality

With the exception of certain specific situations described below, you have the right to the confidentiality of your person health information. The doctor or therapist cannot and will not tell anyone else what you have told them, or that you are in treatment without your prior written permission. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever information is transmitted about you electronically (for example, sending bills or faxing information) all efforts will be made to insure your confidentiality.

The following are legal exceptions to your right to confidentiality. The doctor or therapist will usually inform you of any time when they think they will have to put these into effect.

- If the Doctor or Therapist believes that you are in imminent danger of harming yourself.
- If the Doctor or Therapist has good reason to believe that you will harm another person.
- If the Doctor or Therapist has a good reason to believe that you are abusing or neglecting a child or vulnerable adult.

Except for the situations listed, the therapist will not tell a parent/guardian specific things the minor shares with them in therapy sessions.

Diagnosis and Treatment

1. If a third party such as an insurance company is paying for part of your bill, the provider is required to give a diagnosis to that third party in order to be paid.
2. If you are seeing a physician and therapist at Central Illinois Psychiatric Associates, information regarding your diagnosis, medications, treatment, and progress in therapy may be shared between the providers to insure the best coordination of care possible.
3. You have the right to know about the nature of your condition, the proposed treatment, the benefits and risks of the proposed treatment/medication, and available alternatives to the proposed treatment along with their benefits and risks.

Therapy Sessions and Psychiatric Appointments

1. Once an appointment is scheduled, you are responsible for coming to your session on time and at the time that it is scheduled. If you miss an appointment without canceling, or cancel with less that twenty-four hours' notice, you will be charged **FULL SESSION PRICE**. Central Illinois Psychiatric Associates ***cannot*** bill these sessions to your insurance. No call, no show will be considered automatic termination.
2. As a courtesy, the office as an electronic service that will notify you prior to appointments to confirm your appointment time. You are responsible for keeping your appointment.
3. **If you are canceling your appointment you must call the office.**

PRESCRIPTION POLICY

You have the right to be informed about any recommended medications before consenting to such medication. You also have the obligation to inform your psychiatrist if you are experiencing any adverse effects.

1. It is important that you keep your follow-up appointments with the doctor so that your progress on medications can be monitored; therefore, refills can only be provided to patients who have seen the doctor as directed.
2. You are responsible for initiating a prescription refill **before** you run out of the medication as some medication **CANNOT** be abruptly discontinued or doses missed without the possibility of withdrawal or other adverse effects.
3. Refills for prescriptions can be requested by calling your pharmacy and asking them to fax a refill request to the office. All requests for refills must be called or faxed into our office by 4pm on Wednesday and picked up by 3pm on Thursday. As the office is closed on Friday, any refill request received after 4pm on Wednesday or Thursday will be taken care of on Monday or the following business day if Monday is a holiday. If we are prescribing medications, you cannot concurrently obtain prescriptions for the same or similar medication from another physician or medical office. We also request that you use the same pharmacy for all medications regardless of the provider. Please notify your psychiatrist if you are on any over the counter medication or medications prescribed by other providers.
4. Lost, stolen, or destroyed prescriptions for any medications will not be replaced without proper documentation. Services will be terminated if you modify your medication without authorization.

FEES AND ASSIGNMENT

1. We accept many types of payment for services (cash, personal check, Mastercard®, VISA®, Discover®, Apple Pay®, or insurance payments). However, we do not accept assignment for Medicare, Medicaid (medical card).
2. You are responsible for checking with your insurance company regarding coverage for psychiatric care and psychotherapy.
3. You are responsible, at the time of service, for payment of full, co-pays, deductibles, or fees for services not covered by insurance. In the event your account becomes past due, it may be turned over to a collection agency and/or attorney for collection. If your account is not paid in full and this account is turned over to a collection agency and/or attorney, then you agree to be responsible for all fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees. No refund checks will be issues for under $10.00.

IF YOU BELIEVE THAT YOU CANNOT KEEP YOURSELF SAFE OR NEED IMMEDIATE HELP, PLEASE CALL 911, OR GO TO THE NEAREST HOSPITAL EMERGENCY ROOM FOR ASSISTANCE.

PATIENT CONSENT TO PSYCHIATRIC AND/OR PSYCHITHERAPY SERVICES

Please initial - client/parent or guardian

____ / ____ I understand my rights and the limits to confidentiality required by law. I also understand and agree to the confidentiality considerations for minors in therapy.

____ / ____ I consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process.

____ / ____ I hereby assign my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for all services regardless of insurance coverage.

____ / ____ I understand the risks and benefits of psychotropic medications and psychotherapy and my rights and responsibilities as a patient.

____ / ____ I have read the Office Policies and Information Disclosure Statement had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it.

____ / ____ I agree to receive services from Central Illinois Psychiatric Associates. \

PATIENT NAME: ____
Please print

PATIENT'S SIGNATURE: ______________________________ **DATE**: __________
Required for all patients age 12 and over

GUARDIAN NAME: ____
Please print

GUARDIAN'S SIGNATURE: ______________________________ **DATE**: __________
Required for all patients under the age of 18

WITNESS SIGNATURE: ______________________________ **DATE**: __________

This signature page is to be retained in the patient's file as verification that the patient has read and received the Office Policies and Information Disclosure Statement