INNOVATIVE
PSYCHIATRY
Support. Change. Growth.

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Treatment Consent Form

Please read carefully and initial or sign where necessary

Services Offered

Pharmacotherapy
Psychiatric medications can be used in conjunction with psychotherapy to treat many conditions. It is important to find the best combination of medications and therapy for each individual case. Your provider can provide an integrated approach as they are trained to administer both psychiatric medications and psychotherapy. Additionally, since all medications have the potential for side effects, your provider will always discuss the risks, benefits, side effects, government warnings, and alternative treatments (which always includes not using medication) with you.

Psychotherapy
Often called talk therapy, this form of treatment can be helpful to both individuals and families. Benefits can include significant stress reduction, improved relationships, resolution of specific problems, and improved self-insight. However, therapy is not guaranteed to work for everybody and can be a large financial commitment as well as requiring a significant amount of time and energy. Moreover, psychotherapy may also require exploring unpleasant aspects of your life and can, at times, lead to feelings of distress (i.e., guilt, anxiety, frustration, etc.). These unpleasant aspects are generally temporary but are extremely important to discuss when present. Always remember that anything can be discussed in therapy. Thus, it is important to let our providers know if you feel that your goals are not being met. These issues can be addressed in session.

Fees and Payments
Please be prepared to pay at the time of your visit. Acceptable forms of payment include cash, check and selected credit cards. Service fees may apply for certain item (i.e.: completion of

forms outside of scheduled appointment, telephone appointments longer than 5 minutes, copying of records). We will inform you of any such charge before seeking payment.

Cancelations and No-Shows

Innovative Psychiatry, L.L.C strives to provide personalized care that is tailored to the needs of the individual. To provide such diligent care, it is imperative that patients adhere to appointment times. If there is a need to cancel or reschedule an appointment, please notify the office at least 24 hours prior to the appointment time. **Patients that fail to cancel or reschedule an appointment 24 hours prior are responsible for payment for the requested visit**. In cases as such, our billing staff will contact you to remit payment via credit card or check**.** Please note, three cancellations/no show appointments can result in termination of care.

Insurance Policies

Innovative Psychiatry does not currently accept insurance policies. If you are on a PPO plan, I will be considered "out of network." 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 for out of network providers. I can provide you a paper receipt that you can submit to your insurance company for reimbursement. However, we do not guarantee you will be reimbursed. Furthermore, you are financially responsible for sessions scheduled with Innovative Psychiatry.

Rx Refill Policy

Rx refill requests should be made through the main office number – (443) 542-0773 or the refill request page on our website at www.columbiapsychmd.com Please leave **ALL** details for efficient service, including **name, date of birth, name of medication, dosage, and pharmacy number and location**. **We need 3-5 business day notice for Rx refill.** Please check with your pharmacy after 7:00 PM on the third business day. Due to recent changes in MD drug law, stimulant medication can only be refilled for a maximum of 3 month's without a follow up appointment. You will not get a call back with the status. There is a charge of $5 for mailing prescription payable at your next appointment. Please plan ahead and schedule follow up appointments 1-2 weeks prior to running out of medication.

Professional Records

Mental health records are standard practice in psychiatry and protected by both law and professional standards. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging for our providers to provide you with the full records, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such requests.

CONFIDENTIALITY

Confidentiality is a cornerstone of mental health treatment and is protected by the law. 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, I am 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, I am 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, I 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, I 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 me from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require my testimony through a subpoena. Although these situations can be rare, our providers will make every effort to discuss the proceedings accordingly. Our providers also reserve the right to consult with other professionals when appropriate. In these circumstances, your identity will not be revealed and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Contacting our providers

Our providers attempt to be accessible for all urgent issues. If they are not immediately available by office telephone, please leave a voice message and we will return your call as soon as possible. Calls are generally returned within one business day. In situations that require immediate attention, Dr. Mattai can be reached at (443) 574-6425. Please be judicious when calling Dr. Mattai after normal business hours. **If your call is an emergency, please contact 911 immediately instead of calling the office. Emergency psychiatric services are provided by all hospitals through their emergency rooms and do not require appointments.** When our providers are unavailable for extended periods of time (i.e., vacation, conferences, etc.), phone coverage will be provided by a trusted colleague and contact information will be provided on our office voicemail. Please also note that email should never be used for urgent or emergency issues. This is not a confidential means of communication and our providers cannot ensure that email messages will be received or responded to in a timely fashion.

Initials _____

Treatment Consent

Your signature below indicates that you have read the Treatment Consent Form and you agree to abide by its terms during our professional relationship.

Name of patient (print): _____

Name of legal guardian (print):
_____
**(Only if patient is under 18 or a dependent adult)* Signature of patient or guardian:

Signature:_____ Date: _____

Signature of psychiatrist: _____
Date: _____

Policy and Contract Regarding Controlled Substances

-I have been prescribed a controlled substance medication for the treatment of a psychiatric condition (ex: Adderall for ADHD, Ativan for an anxiety disorder).

-I understand these medications are **controlled substances** and are tightly regulated by state and federal law with a high risk for abuse. **Therefore, the prescription must be written and can be for only one month's supply**. I understand that it is a **FELONY** to obtain these such medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others (diversion of medications). **I understand that Innovative Psychiatry will also utilize the State of Maryland's CRISP system to track controlled substances.**

-As a result, I will not seek to have duplicate prescriptions written for me of the same medication. I acknowledge that violation of these policies concerning controlled substances will result in termination of my care. In some instances it may be necessary to inform federal state and local authorities of suspected misuse of medication. **Furthermore, I acknowledge that it is my responsibility to protect the written prescription and medication.**

-Our providers require medication follow up visits every month for the first six months and until the dose of medication is stable. If appointments are not kept my prescriptions **will not be renewed.** Prescription renewal requiring an appointment will be provided only during a scheduled appointment and not on an emergent basis. Missing several appointments will result in denial of controlled substance medications. Because mixing controlled medication with illicit substances can be unsafe, our providers may request a voluntary urine drug screen prior to providing a prescription. The results of such testing can affect the decision to provide a written prescription.

-Prescriptions will not be renewed earlier than 25 days from the previous prescription date – no exceptions. We will also ask you to identify the pharmacy you use to fill such medications.

-I agree to follow the terms of this agreement. Any questions or concerns regarding this agreement have been addressed.

Patient Name: _____

Patient Signature: _____

Date: _____

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Authorization for Release of Information

Client's name: _____ Date of Birth: _____
Address: _____ City, State, Zip: _____

□ I authorize Innovative Psychiatry LLC, my provider, _____ to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

□ I authorize Innovative Psychiatry LLC, my provider, _____ to obtain information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # Fax #

PURPOSE OF THIS REQUEST: (check one) □ Healthcare □ Insurance □ Personal
□ Other (please describe) _____

SPECIFIC INFORMATION AUTHORIZED FOR RELEASE BY INNOVATIVE PSYCHIATRY LLC
□ Treatment History
□ Telephone Communication
□ Other (please describe): _____

I understand that:
- This authorization is voluntary and refusing to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Innovative Psychiatry LLC, except where a disclosure has already been made in reliance to my prior authorization
- This information that is disclosed pursuant to this authorization may be re-disclosed to by the recipient unless the recipient is covered by state or federal laws that limit the use and/or disclosure of my confidential protected health information.

_____
Date Client Signature or Signature of Parent/Guardian Print name of Client or Parent/Guardian

HIPAA PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

_____

Patient Signature (Parent or Guardian if Patient is a Minor)

_____

Relationship to Patient (If Other Than Patient)

_____

Date

ELECTRONIC COMMUNICATION

It is impossible to guarantee the confidentially of email or text message content. By this notice you grant Innovative Psychiatry, permission to email and text message you. You acknowledge the risks and release Innovative Psychiatry from liability for the risk of your confidentiality. Our providers typically return text messages and emails within 24 hours during the week. Emails and text messages should be limited to administrative issues such as scheduling. Our providers do not accept friend requests from clients on Facebook, Linked In or other social media websites.

Please sign here that you acknowledge and agree to the above statement:

Print Name: _____

Signature: _____

Date: _____