

Powder Day Enterprises, P.C.

4141 East Dickenson Place, Denver, Colorado 80222 ❖ Tel. (303) 504-6565 ❖ Fax (303) 321-1040 ❖ www.wbscolorado.org

Important Patient Information

Client Name: _____ DOB: _____

Welcome!

Your first visit to POWDER DAY ENTERPRISES, P.C. is an important one.

The first visit is a thorough clinical evaluation. There are several things that occur during this visit, which may be intentionally longer than any subsequent visits.

First, and foremost, our psychiatrist would like to understand the reason you are seeking help and whether the services we offer can best support you in achieving your expectations for coming here.

We will review with you your history and any problematic symptoms that you experience along with what *you* want to change in your life.

Together with you, we will determine if there is a good treatment match which includes both the course of treatment and the high probability of a 'therapeutic alliance' between you and your physician here.

We will use our expertise and experience to recommend a course of treatment that will offer you the best likelihood of treatment success.

Our experience and the research literature is clear that treatment success is highly weighted toward your motivations and authentic participation in your treatment.

We are looking for several *alignments*: the extent that treatment can be delivered with an outpatient *frequency, agreement* on the types of treatment interventions and outcomes between you and your physician, and *your active participation* in improving your wellness.

There are a number of possibilities where treatment **here** may not be indicated. A few examples are:

- Symptoms cannot be successfully treated by one provider.
- Treatment goals cannot be agreed upon.
- Best treatment options are elsewhere.
- Not a good physician/patient fit.

The first visit is where you and the physician determine if treatment with POWDER DAY ENTERPRISES, P.C. will begin.

We value your wellness and your time and our interest is solely in establishing the right conditions for your improvement and success.

I have read and understand what will occur on my first visit.

Client or Parent/Guardian Signature

Date

Client ID: _____

10/28/2009

POWDER DAY ENTERPRISES, P.C.

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POLICIES AND PROCEDURES

Client Name: _____ DOB: _____

Welcome to POWDER DAY ENTERPRISES, P.C. Our goal is to provide you and your family timely, respectful, quality service in a pleasant practice environment.

HOURS

POWDER DAY ENTERPRISES, P.C. is open by scheduled appointment only. When the office is closed, a brief voice mail message can be left on the scheduling voice mailbox or on the Practice Administrator's voice mailbox.

APPOINTMENTS

Appointments can be scheduled through POWDER DAY ENTERPRISES, P.C. We do not over-book or double-book; the time you schedule is yours. If you cannot or do not plan to keep your appointment, please let us know at least one work day (24 hours) in advance to avoid a charge.

EMERGENCIES

If you have an immediate life and death emergency, call 911 or go promptly to an Emergency Room or Urgent Care for assistance. During office hours, your doctor will return calls as possible between patients. We make a strong effort to return all patient calls on the day received (please be sure we have current home, cell, and work phone numbers) and at least by the end of the next working day. If you feel your concern is urgent, please make this clear to the Practice Administrator so that we cannot underestimate your concern. Please do not hesitate to call back. You may also find it helpful to contact your therapist or primary care physician.

AFTER HOURS / HOLIDAYS

If you have an immediate life and death emergency, call 911 or go promptly to an Emergency Room or Urgent Care for assistance. After hours, weekends, and holidays, please contact your doctor per the after hours instructions given to you at your initial appointment.

PRESCRIPTION REFILLS

POWDER DAY ENTERPRISES, P.C. psychiatrists' routine practice is to write a prescription(s) to cover your needs until your next appointment. There should be no need for additional refills if you keep scheduled appointments or reschedule promptly. If an exception occurs, please call the pharmacy (during business office hours, at least two working days before you will run out) and ask them to call the office to approve a refill. POWDER DAY ENTERPRISES' psychiatrists will refill prescriptions during business hours, for active patients with scheduled follow-up appointments. *A fee will be assessed for refills provided between scheduled appointments.* Patients are generally seen at least monthly at first, then up to every two months when well established, and occasionally up to every three months. Persons not seen in over four months are not considered active or current patients of POWDER DAY ENTERPRISES, P.C. Medication changes generally require appointments so they can be adequately considered, explained, and discussed. Refills will only be approved for current patients who have scheduled follow-up appointments. Controlled substances (Ritalin, Adderall, Dexedrine) cannot be refilled by phone and will not be rewritten except during an appointment.

If another psychiatrist is covering for your primary psychiatrist, the covering psychiatrist will often hold refills until your doctor returns, if possible, or may approve only enough medication to cover the patient's needs until your primary doctor returns.

DOCTOR-PATIENT RELATIONSHIP

POWDER DAY ENTERPRISES, P.C. psychiatrists become you or your child's primary psychiatrist (doctor) when a mutual agreement is made to work together after the initial evaluation (usually one to three appointments) is completed. This relationship is a professional, cooperative partnership in which we both have responsibilities to work toward agreed-upon goals. Because of the nature of psychiatric treatment, a person or family must be seen at least every three months to be considered an active or current patient of POWDER DAY ENTERPRISES, P.C.

INITIALS

RECORDS

There is generally no fee for copying and mailing records of fewer than five pages. Beyond this there is a charge of 25 cents per page plus postage, to cover costs and staff time. A completed, signed release of information is required.

PAYMENT

Copayment or payment-in-full is due at the time of service, payable to "MHCD" on behalf of POWDER DAY ENTERPRISES, P.C. Personal checks, cash, Visa, MasterCard, American Express, and Discover are accepted. We cannot make change.

RETURNED CHECKS

There is a \$25 charge for returned checks.

INSURANCE

POWDER DAY ENTERPRISES, P.C. will bill your insurance. A copy of your insurance information will be kept on file in our office. Please inform the Practice Administrator in a timely manner if there are any changes to your insurance policy. Your insurance policy is a contract between your insurer and you. You are responsible for all charges incurred, as well as for any services that are not covered by your policy, such as telephone consultations, testing, and reports.

MISSED APPOINTMENTS

There is a fee for appointments missed, canceled, or changed *less than one business day (24 hours) in advance*, except when, at the discretion of the clinic, there exists dangerous weather conditions, serious illness, or a life-threatening emergency, or if we are able to schedule another patient during the appointment slot you have canceled. For example, if you have a Monday appointment scheduled for 3:00, you must notify us of any change no later than 3:00 the previous Friday (or sooner if that Friday is a holiday).

Please remember, this is fully your time. We do not over-book or double-book appointments. Please notify us promptly if you cannot make your appointment so that we can offer the time to someone else. The missed appointment fee equals the full amount that would have been received for your appointment. For patients not using insurance, the fee is the standard rate for the scheduled appointment. For patients using insurance, the fee equals the amount of your standard payment (copay, coinsurance, or deductible) *plus* the amount that would have been reimbursed by the insurance company. Insurance does not cover missed appointments.

REPORTS, EXTENDED CALLS, LETTERS

Due to the additional time and costs incurred, there is a charge for extended or complex phone calls, and for letters, reports, medication authorizations, or extended calls done on your behalf to other clinicians or insurance companies/agencies.

HIPAA

HIPAA is a federal law to improve privacy and Internet transactions for billing and records. POWDER DAY ENTERPRISES, P.C. meets or exceeds HIPAA privacy standards.

Client or Parent/Guardian Signature

Date

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FEE AGREEMENT

Client Name: _____ DOB: _____

POWDER DAY ENTERPRISES, P.C. is pleased to have you receiving services here.

Payment Agreement

- I understand that I am financially responsible for services received at POWDER DAY ENTERPRISES, P.C..
- I understand that full payment is due at the time of appointment.
- I understand that I am responsible for any lab services and medications that I might receive.

FULL FEE

- I understand that I am financially responsible for paying full fee for services and have received a copy of POWDER DAY ENTERPRISES, P.C.'s usual and customary fees.
- I understand payment is due at the time of appointment.
- I understand that I am responsible for any lab services and medications that I might receive.

CONTRACTED INSURANCE BENEFITS / ASSIGNMENT OF BENEFITS

- I hereby authorize POWDER DAY ENTERPRISES, P.C. to bill my insurance carrier on my behalf and to receive direct payment for any insurance benefits payable for the services provided by POWDER DAY ENTERPRISES, P.C..
- I hereby assign to POWDER DAY ENTERPRISES, P.C. any insurance or other third-party benefits available for health care services provided to me. I understand that POWDER DAY ENTERPRISES, P.C. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to POWDER DAY ENTERPRISES, P.C., I agree to forward to POWDER DAY ENTERPRISES, P.C. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.
- I authorize POWDER DAY ENTERPRISES, P.C. to release to my insurance carriers any information requested by the insurance company.
- I understand that I am legally responsible for paying copays, co-insurance, and deductibles that are part of my insurance benefit.

Name of Insured: _____ DOB: _____

Benefit/Insurance Company: _____

ID Number: _____ Group Number: _____

Benefit Summary: Deductible: \$ _____ Amount Met: _____ Date Checked: _____

Co-Insurance: _____ % Copay: \$ _____ Visits Allowed: _____

I understand that I am financially responsible for services received at POWDER DAY ENTERPRISES, P.C. according to this Fee Agreement. I have read and fully understand the content of the Fee Agreement. I acknowledge that the information I have given is true and correct to the best of my knowledge

Client or Parent/Guardian Signature: _____

Date: _____

Client ID: _____

REV 10/28/2009

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CONSENT FOR SERVICES • CONFIDENTIALITY • TREATMENT RIGHTS

Client Name: _____

DOB: _____

Consent for services/evaluation:

I voluntarily apply for and consent to diagnostic and treatment services provided by the qualified mental health professionals of Powder Day Enterprises, P.C. I am aware that the mental health services are not based on an exact science and that the type(s) of treatment received will depend primarily on my needs and abilities. I understand that, as such, I cannot be given any guarantees about the results of treatment services. I agree to participate in evaluation research conducted for the purposes of assessing my progress in treatment and my perceptions of the treatment provided by Powder Day Enterprises, P.C. I understand that I may be contacted for such purposes while in treatment and/or after I leave the treatment program. I understand that I may withdraw my consent at any time.

Confidentiality and records release:

I understand that any information about me, including treatment records, is confidential to the extent that local, state and federal laws and regulations allow. I understand that exceptions to confidentiality will be made if there is suspicion of child abuse or neglect, if I am gravely disabled, or if I show imminent danger to myself or others. There are other exceptions that will be identified as the situation arises. I understand that release of my clinical records may ONLY be accomplished with my written consent or the written consent of a person authorized as my agent. I understand that following such release of my clinical records, Powder Day Enterprises, P.C. will no longer be responsible for the confidentiality of any of the documents released in accordance with the consent. I also understand that separate authorization may be processed for release of information for purposes other than those described in my clinical record release forms or my release forms for collection of third-part reimbursement.

Treatment rights:

Below is a list of treatment rights you have while you receive services with Powder Day Enterprises, P.C. These rights have been established by the Colorado Division of Mental Health Standards, Rules and Regulation of the Colorado Mental Health System, June 1, 1992.

1. To be treated with respect and dignity.
2. To receive services which are suited to individual needs, in the least restrictive setting in keeping with available resources.
3. To have a service plan established for your treatment and to participate in the decision making process in developing your service plan. To have your service plan reviewed every six months by the professional staff assigned to supervise and implement your treatment program
4. At your request and at your expense, you have the right to consult with a specialist about your service plan and to seek a second opinion.
5. To have the professional person in charge of your treatment explain the procedures and medications that will be used, including the benefits, any risks and side effects.
6. To refuse the services offered to you, unless an emergency exists or a court order is in effect.
7. To have your treatment and clinical records be kept confidential except when release of such information is authorized by law.
8. To see your records or have them shown to any person that you designate in writing according to Colorado law. You may be denied access to your records in limited circumstances. If you are denied access to your records, you have the right to know why and the right to appeal this decision.
9. To complain or grieve about the services you are receiving or about the denial of services or treatment rights. No retaliation can be made against you for complaining.
10. To receive assistance from the consumer representative in making complaints or grievances and to receive copies of the complaint/grievance procedures.
11. To understand the risks and benefits of experimental programs or research and to refuse to participate in such projects.
12. To be given the names and professional status of the staff member(s) responsible for your care.
13. To be given the reasons for any proposed changes in the professional staff responsible for your care.
14. To terminate receiving services from Powder Day Enterprises, P.C. unless there is an involuntary treatment order from the court. Powder Day Enterprises, P.C. also retains the right to terminate providing services to you.
15. To have a staff person or the consumer representative explain these rights to you in a language that you understand best.

By signing, I acknowledge I have read, understand, and have received a copy of the above statements of consent, confidentiality, and treatment rights. I also acknowledge that I have received a copy of the Notice of Privacy Rights.

Client or Parent/Guardian Signature:

Date:

Witness Signature:

Date:

Client ID: _____

REV 09/17/2009