**Memorial Park Psychiatry**Child, Adolescent and Adult Psychiatry

550 Westcott Houston, TX 77007 Suite 520

Phone: 713-864-6694 Fax: 713-864-6698

Provider: Dr Alice Mao [ ]  Dr. Matthew Brams [ ]  Dr. Monica Grover [ ]  Nicole Lisberg PHMNP [ ]

Surya Abraham PHMNP [ ]  Amy Eris PHMNP [ ]  Ian Smalling FNP [ ]  Michael Abiodun PHMNP [ ]

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Legal Custody Of (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M [ ]  F [ ]

Marital Status: [ ]  Single [ ]  Married [ ]  Divorced [ ]  Widow

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (or responsible party): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Evaluation or Treatment By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to Contact: [ ]  Yes [ ]  No

Please pick the best form of contact for a reminder:

Home [ ]  Cell [ ]  OR Text [ ]  Work [ ]  Email [ ]

**Pharmacy Information**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Memorial Park Psychiatry
550 Westcott, Suite 520
Houston, TX 77007**

**Phone:** **713-864-6694 Fax: 713-864-6698**

**Consent to Services**

**Please read, initial and sign:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby request and consent to psychiatric services for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 These services include, but are not limited to, routine crisis screening, diagnostic assessment, laboratory testing and other treatment and diagnostic services recommended by my designated provider.

I understand that upon completion of assessments a more detailed plan of care may be developed by my physician and will be explained to me. I understand that I have the option to accept or reject any recommendations for any and all services. I have been advised that I am financially responsible for any and all services provided by and through Memorial Park Psychiatry unless payment has otherwise been assured. I acknowledge that such services may include clinical and ancillary testing services that may be provided through affiliated or contracted management services organization in which Memorial Park Psychiatry may financially benefit from.

I have been informed that any information regarding my psychiatric services is subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that identifying information about me may be exchanged between the aforementioned physicians for coverage purpose; or continuity of care purposes.

I authorize the release of any medical or other information necessary to process my medical claims.

I authorize payment of medical and ancillary testing benefits to Memorial Park Psychiatry (MPP MSO PLLC) or its suppliers for services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient/Legal Guardian's Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date

NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN ACT TO GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice and make the new Notice available upon request.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy policy and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our private practices, we will change this Notice and make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use of disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services**: We will not use your health information for marketing communications without your written authorization.

**Required by Law**: We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this

Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25 for the first 20 pages and $0.50 per sheet after that and staff time to locate and copy your health information, and postage if you want the copies mailed to. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary of an explanation of your information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

**Disclosure Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 (six) years, but not before October 28, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment**: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice**: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Memorial Park Psychiatry

Telephone: 713-864-6694 Fax: 713-864-6698

Address: 550 Westcott, Ste. 520 Houston, TX 77007

Notice of Privacy Practices Acknowledgement

Memorial Park Psychiatry
550 Westcott , Suite 520
Houston, TX 77007
Phone: 713-864-6694
Fax: 713-864-6698

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

**Memorial Park Psychiatry**

550 Westcott, Suite 520

Houston, TX 77007

Office: 713-864-6694 Fax: 713-864-6698

**OFFICE POLICIES**

We are committed to providing you with quality medical care and we are pleased to discuss our office policies at any time.
Your clear understanding of our office policies is important to our professional relationship.

*Please ask if you have any questions about our office policies, fees, financial policy, or your responsibility.*

**TO ASSIST US IN ESTABLISHING YOUR ACCOUNT, PLEASE PROVIDE THE FOLLOWING:**

1. Current insurance information on your registration.
2. Please present your insurance card so that a copy may be made for your chart.
3. A separately signed consent disclosure for authorization for the release of information necessary for filling your insurance claim(s), faxing orders, releasing medical information to other physicians and/or for insurance pre-certifications.
4. Please note that **all copays** designated by your insurance plan **will NOT be billed** and are **DUE AT THE TIME OF SERVICE**.

**INSURANCE**

***Insurance is a contract between you and your insurance company.*** We are not a party to your contract, though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance regarding deductibles, non-covered/covered expenses, co-insurance or “reasonable and customary” charges other than to supply factual information as necessary. **You are responsible for timely payment of your account and for following up with your insurance company regarding claims.**Our staff is very knowledgeable in referral authorization, pre-certifications and pre-authorization procedures for all insurance plans. Please note that at times, you may be required to contact your insurance company regarding specific mental health benefits and/or prior authorizations.

***It is your responsibility to provide the office with any changes or updates to your insurance plan.***

**Fee for Service**: As a courtesy to our patients, we file with your insurance provided you have met your annual deductible and pay your co-insurance as the time of service. *If you have not met your deductible you must pay at the time of service and a claim will be filled with your insurance.*

**Contracted Managed Health Care**: (HMOs, PPOs, EPOs) **It is your responsibility to make sure that our clinic is currently enrolled with your plan. All necessary referrals must have been obtained prior to each visit.** If your referral has not been completed prior to your arrival in the office, it may mean a delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the co-pay at the time of your visit.

**Worker’s Compensation**: We **DO NOT ACCEPT** Worker’s Compensation patients.

**APPOINTMENTS**

**Please make note that reminder calls are a courtesy. You are ultimately responsible for your appointment whether your reminder was received or not.**

Due to frequent rescheduling and/or cancellations of appointments by our patients in the past, it has become necessary to apply an administrative charge for missed appointments and/or same day (non-emergency) cancellations.

**A PATIENT WHO RESCHEDULES OR CANCELS WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT FOR ANY REASON OTHER THAN A MEDICAL OR OTHER EMERGENCY ISSUES (DETERMINED AT THE DISCRETION OF THE OFFICE), OR WHO DOES NOT SHOW UP FOR THEIR SCHEDULED APPOINTMENT, WILL BE CHARGED A FEE OF $75.**

If you are running late, we ask that you contact our office to let us know. If you fail to contact the office and show up more than 10 minutes late to your appointment, you may have to be rescheduled for a different day and will be charged for a missed appointment.

**If you no-show for two appointments, at the discretion of the office, you will be sent a termination letter and will not be permitted to schedule another appointment.**

Although the clinicians try their best to stay on schedule, we ask that you make time in your schedule in case you encounter a longer than normal wait time. This is not a common occurrence, but we ask for your patience and courtesy, should this occur.

**OTHER IMPORTANT POLICIES**:

There will be no early refills on any controlled substances. No exceptions

Mediations cannot be sent across state lines especially controlled medications (benzodiazepines, stimulants, sedative hypnotics)

Refill requests should be made a minimum of **3 business days** before you run out of medications.

A yearly urine drug screen can be requested by the provider and repeated as necessary for maintenance.

Providers have the right to request that patients attend psychotherapy if indicated. IF patient refuses to attend, provider has the right to terminate care.

Only psychotropic medications are prescribed in this office. Providers will not refill antibiotics, blood pressure mediations or other primary care medications.

In order to receive refills patients must be compliant with their follow-up appointments which are at a minimum every 3 months. If making changes to your treatment plan the providers will require sooner follow-up appointments and will inform you of when your follow-up should be.

If patients are in violation of office policies, noncompliant with treatment plan, or reach a level of acuity beyond that which the provider deems appropriate for outpatient treatment the relationship between patient and MPP can be terminated.

If patients display inappropriate behaviors, verbal or physical in nature towards providers or staff they will be terminated.

**ON-CALL CLINICIAN SERVICES**

In the event of an urgent psychiatric matter outside of regular business hours, you may contact the answering service by calling our office and having the clinician paged. You will be asked to explain the nature of your emergency. You will receive a return telephone call promptly. Please note, the providers cannot perform any emergency intervention via phone or send in any controlled substance outside of business hours. Please note that this service should be utilized for urgent matters that cannot wait until the next business day only. However, serious or life threatening matters including suicidal thoughts with plan, intent or actions of harming self and/or others, serious medication reactions, or unusual behavior that may lead to physical harm should report straight to the ER or psychiatric hospital of choice... Non-urgent issues (i.e. medication refills, scheduling or billing questions) may be addressed via telephone during our regular business hours, and are not considered emergencies.

**Calls placed for non-emergent issues will result in being charged a $25 fee for after-hours care. It is the patient’s responsibility to ensure they have enough mediation available for weekends and holidays.**

**EMERGENCY CARE**

In the event of a life-threatening emergency, please call 911 or go to the nearest Emergency Room, Memorial Hermann Crisis Clinic or the psychiatric hospital of choice. Do not delay care by waiting for a response from our on-call provider. There are limited interventions the providers can provide being that this is an outpatient practice. Controlled substances cannot be called in outside of business hours.

**MINORS/UNACCOMPANIED MINORS (less than 18 years of age)**

1. The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status.
2. The parent(s) or legal guardian(s) for an unaccompanied minor must provide authorization for medical treatment and is responsible for providing current insurance information and any necessary payment at the time of service.
3. The parent (s) or legal guardians must be available and present for appointments for any minor.

**ADDITIONAL FEES**

1. There is a charge for all letters and forms (including but not limited to FMLA forms, Short and Long Term Disability, Social Security Disability, etc.). This fee ranges from $30 and increases, depending on the length and nature of the paperwork. The exact charge will be determined by the clinician. We will try our best to get paperwork back to you within 5 business days. Rush orders are an additional $20 (paperwork needed within 48 hours)
2. There is a fee for all medical records request. $25 for the first 20 pages and $0.50 per sheet thereafter.
3. There is a $25 fee on all returned checks.
4. There is a $25 charge for all medications needing prior authorization for coverage