Patient Agreement with
Policies and Procedures

Welcome to OUR practice!

The following information is provided to our patients to assist you in understanding policies and procedures at our office. We strive to provide you care which is both comfortable and of the highest quality. Please do not hesitate to ask questions of the administrative staff at any time about these matters

Attached to the Patient Agreement Form is the newly required **Notification of Patient Rights** document now required with the passage of the federal "medical records privacy act" known as HIPAA (Health Insurance Portability and Accountability Act). We are required by law to give you a copy of this document and to secure your signature indicating you have received your copy of it. Laws such as these are important, but also complex and in our Notification of Patient Rights document we have tried to inform you about your rights in plain, simple language. Please read the contract and do not hesitate to ask us about any questions you might have about these matters.

Appointments

Patients are seen by appointment only (unless an emergency situation dictates otherwise), the appointment time given is reserved for you. Please give at least *twenty-four (24) hours notice* if you must cancel your reserved time. Sometimes illnesses and emergencies happen which prevent you from keeping your reserved time, and we do not charge a fee for these infrequent occurrences. *In the absence of such circumstances, you will be charged an office visit charge for your scheduled appointment* for appointments not cancelled 24 hours prior to the time.

Emergencies and Telephone Calls

While you will be seen at a reserved time which fits your schedule demands, there may arise occasions where you need to talk to us between appointments. Should you need to talk to us between appointments and you call during normal office hours, we will return your call as promptly as we can. If you call is an **emergency** and occurs during normal office hours, *you should declare your call to be an emergency to the office staff or answering service.* Your call will be handled promptly. We have twenty-four (24) hour emergency services. All after hour calls will be treated as appointments and will be charged accordingly.

Fees and Payments

Payments are due at time services are rendered. We accept all major credit cards, checks, and cash. We do not file insurance, but you may file on your own behalf. We will furnish you with a receipt with the information needed to file your claim.

Your Informed Consent to Care

We have provided this information to you in the hope of fully informing you about the policies of the office and some of the parameters or care you will receive here, such as the importance of confidentiality. *Psychiatric and psychological care, like other things in life, offer not absolute guarantee of success and there are limitations to any form of care offered to a patient*. Since such limitations are always a function of the particular problem in question, we invite you to discuss your treatment plan with us. After we have met to discuss your concerns, we will construct an individualized treatment plan and share it with you so that we have our plan for what problems we are going to solve and how.

Please feel free to discuss any of these matters with us in more detail. By signing below, you acknowledge having read, understood, and agreeing to these policies and procedures. Your signature acknowledges your informed consent to care.

_____ _____

Signature of adult patient or parent/legal guardian of patient Date
Less than 18 years of age

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPPA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and the storage and access to health care records ("the security rules"). HIPPA applies to all health care providers, including mental healthcare, and healthcare agencies throughout our country. They are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPPA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My patient notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important for you to know what patient protections HIPPA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions, about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

I, _____, understand and have been provided a copy of Memphis Psychiatric Services Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand and have the right to review this document before signing this acknowledgement form.

_____ _____

Patient Signature or Parent if Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____

RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, give my consent for Memphis Psychiatric Services to contact and/or release my protected health information to the following:

☐ PCP Name: _____ Number: _____

☐ Therapist Name: _____ Number: _____

☐ Specialist Name: _____ Number: _____

You may contact or discuss my therapy and/or account with the following:

☐ Partner/Spouse Name: _____ Number: _____

☐ Mother Name: _____ Number: _____

☐ Father Name: _____ Number: _____

☐ Other Name: _____ Number: _____

Pharmacy: _____ Phone: _____

Location: _____

This release allows us to correspond by mail, email, text, fax or phone and discuss appointments, your therapy, medications, insurance and all other aspects of your case while under the care or Memphis Psychiatric Services. This release allows us to access your medication history from the pharmacy listed above.

You must notify MPS in writing with any changes to this release. This release will remain active and valid until your case is closed or written notification of changes is received.

By signing below, you are acknowledging you have read and understand that this form releases your protected health information and you have approved this release.

Signature_____ Date_____
(patient/parent and/or guardian)