Geriatric and Adult Psychiatry, LLC
60 Washington Avenue, Suite 203
Hamden, CT 06518
Phone: (203) 288-0414 Fax: (203) 288-3655

PRACTICE POLICIES

Patient Name: _____ DOB: _____

I have reviewed the policies mentioned below with the patient advocate. I understand that if I do not meet the agreements made today that I can be discharged from G.A.P Clinical Care and Research Center.

Patient Responsibilities

The following office policies have been explained to me; my legal representative; my family member, and/or caregiver.

- Financial agreement
- Commitment to treatment/Discharge policy

Services not covered by Insurance

The Advanced Beneficiary Notice of Non-coverage has been reviewed with me; my legal representative; my family member, and/or caregiver.

- No Show/Cancellation without 24-hour policy ($75 fee per event)
- Case Management services: ____One Time Fee ____ Charge per event

Privacy Acknowledgement (HIPAA)

I; my legal representative; my family member, and/or caregiver understand the notice of privacy practice, also known as HIPAA. I understand my medical records are protected and will only be released with: 1) My written consent. 2) If I have been hospitalized, or 3) I am at a serious health risk and require urgent care.

Email/Electronic Chart Enrollment

I; my legal representative; my family member, and/or caregiver understand when providing an email this will allow sensitive information via electronic submission regarding my medical care to myself or person(s) of my choice. I have signed a written release of information.

Insurance Authorization and Assignment

I; my legal representative; my family member, and/or caregiver understand to authorize any holder of medical or other information about me to be released my insurance provider or its intermediaries or carriers any information needed for this insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31. U.S.C. 3801-3812 provides penalties for withholding this information).

Signature: _____ Date: _____

If signed by the Legal Representative, indicate your relationship to the patient. Documentation to verify your authority is required.
Conservator _____ Power of Attorney ____ Family Rep.____ Financial Resp.Party ____ Caregiver____

_____ _____ ____ YES ___NO, copies declined
Policies & ROI's have been reviewed with Initials of employee Copies of polices provided.

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FAMILY OR PERSONAL RELEASE OF INFORMATION

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorizes **to** use or disclose health information, including, if applicable, information relating to the diagnosis or treatment of mental illness to any names of person(s) personal to me whom I list below.

Patient Name: _____ DOB: _____

Geriatric and Adult Psychiatry, LLC has my permission to speak with:

1. Name: _____ Relationship: _____

Primary #: _____ Other #: _____

2. Name: _____ Relationship: _____

Primary #: _____ Other #: _____

Information to be released:

- Financial information: ___Yes ___No
- Medication questions or changes: ___Yes ___No
- Permission to speak with my clinician regarding medical care: ___Yes ___No
- To call on my behalf to discuss cancelled or reschedule appointments: ___Yes ___No

The purpose of this disclosure is for medical and psychiatric care. I understand that I may revoke this authorization at any time by providing written notice to G.A.P. Clinical Care & Research Center, LLC, but if I do, it will not have any effect on actions that G.A.P. Clinical Care & Research Center, LLC took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

Signature_____ Date_____

If signed by the Legal Representative, indicate your relationship to the patient below. Documentation to verify your authority must be provided.

Conservator _____ Power of Attorney ____ Family Rep.____ Financial Resp.Party ____ Caregiver____

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EMAIL AUTHORIZATION TO ACCESS MEDICAL RECORDS

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorizes **Geriatric & Adult Psychiatry, LLC** to use or disclose health information, including, if applicable, information relating to the diagnosis or treatment of mental illness to any names of person(s) whom I list below that are personal to me and not a medical provider.

Patient Name: _____ DOB: _____

I understand that providing Geriatric & Adult Psychiatry, LLC with the following email address(es) to those listed, will grant them access to my medical records.

1. Name: _____ Relationship:_____

Cell #: _____ Other #: _____

Email on file: _____

Geriatric & Adult Psychiatry, LLC will not be liable for any information that is shared by the person(s) named above, once this access is granted to view:
Demographic/ insurance information; Diagnosis history, procedure & care plans in signed documents; medication/ allergy list; lab results/immunizations; and/or scheduled appointments.

The staff at Geriatric & Adult Psychiatry **will not** respond or review emails and/or electronic communication delivered by our electronic medical records system (Patient Fusion). All communications pertaining to patient care must be received by contacting the office during business hours or contacting our answering service.

I understand that I may revoke this authorization at any time by providing written notice to G.A.P. Clinical Care & Research Center, LLC, but if I do, it will not have any effect on actions that Geriatric & Adult Psychiatry, LLC took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

Signature_____ Date_____

By signing this document, that means you received and understand this notice.

If signed by the Legal Representative, indicate your relationship to the patient. Documentation to verify your authority required.
Conservator _____ Power of Attorney ____ Family Rep.____ Financial Resp.Party ____ Caregiver____

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HIPAA ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that **Geriatric & Adult Psychiatry** has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact: Privacy Officer (203)288-0414

I also understand that I am entitled to receive updates upon request if Geriatric & Adult Psychiatry amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature of patient or of patient representative Date

_____ _____
Name of patient representative (Print) Relationship to patient

Everything below this line is for OFFICE USE ONLY

THIS SECTION IS TO BE COMPLETED BY GERIATRIC & ADULT PSYCHIATRY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____
Name and title of employee Date

Advanced **B**eneficiary **N**otice of **N**on-coverage (ABN): **No Show/Cancellation Fee**

G.A.P. Clinical Care & Research Center, 60 Washington Ave, Suite 203, Hamden CT 06518

Your insurance company does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance company may not pay the No Show/Cancellations without 24-hour notice fee and that you will be billed privately for these events.

Reason your insurance company may not pay for No Show/Cancellation without 24-hour notice fee
When you do not come to your appointment, our staff time will not be paid for by your insurance company. Insurance companies pay only for face to face contact. For cancellations, provided that you give us sufficient advance notice, we will try to fill the time slot with another patient and thus avoid a charge to you.

Cost: $75.00 per event

Financial Responsibilities

I understand that I am responsible for providing accurate insurance information and then updating GAP Clinical Care & Research Center with any changes in my insurance coverage.

I am responsible for the entire amount of my visit with GAP Clinical Care & Research Center if my insurance does not pay for any reason such as:

1. I failed to obtain a referral from my primary care doctor
2. I failed to inform the office of any changes in insurance(s)
3. My insurance policy was cancelled at the time of my visit
4. I understand I am responsible to pay my co-pay at the time of each visit.
5. If I am having difficulty paying my portion of any costs, I agree to meet with the finance department to make arrangements.
6. If at any time, I do not have insurance or choose not to utilize my insurance coverage, I will be responsible to pay for each visit prior to being seen.

PATIENT RESPONSIBILITIES

COMMITMENT TO TREATMENT

I understand that GAP Clinical Care & Research Center is committed to delivering excellent care.

I understand that benefiting from treatment requires that I come to my appointments on time. If I am late I understand that my session time will be decreased and end at its normal time. If I miss my entire allotted time, I may be required to reschedule.

I understand that the G.A.P Clinical Care and Research Center's policy for obtaining medication refills requires that I be seen within three months. Exceptions can be made on a case by case basis for those who leave Connecticut for the winter or if unexpected emergency arise.

I understand that I will be automatically discharged from G.A.P Clinical Care and Research Center if I am not seen as described in my treatment plan or after 8 months from my last appointment has passed. In order to resume services at GAP, I would have to come in for another evaluation.

My treatment can be immediately terminated if I display verbal abuse or any type of threat to G G.A.P

Advanced **B**eneficiary **N**otice of Non-coverage **(ABN):** Case Management Services

G.A.P. Clinical Care & Research Center, 60 Washington Ave, Suite 203, Hamden CT 06518

Your insurance may not pay for all services, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the following Case Management Services, and you will be billed privately for these non-covered services.

Case Management Services include:

1. Frequent or extended telephone calls; calls from multiple family members or providers (more than 5 minutes)
2. Applications for insurance coverage or home care assistance
3. Assistance with simple legal forms/letters
4. Disability or work related forms/letters
5. Psychiatric, assisted living and nursing home applications
6. Prior insurance authorizations for medications

Reason that your insurance may not pay for services: Insurance companies usually do not pay for any case management services. Typically, only the actual face to face visit and brief medically necessary phone contact is covered. If your care requires additional services, we can provide them to you with the understanding that a separate fee is required from you.

Costs:

- Itemized Case Management Services – Charged per event
  - Physicians: $50 per 15 minutes
  - Advanced Practice Nurse Clinicians: $40 per 15 minutes
  - Licensed Clinical Social Workers: $35 per 15 minutes
  - Administrative and clerical staff: $25 per 15 minutes
  - Prior authorization for medications denied by insurance: $35 per event

- Packaged Case Management: $150.00 – One Time Fee (non-refundable)
- **NOTE:** This case management service does not apply to court appearances on my behalf. I do understand that I or my attorney will be billed an additional fee.
- Make an informed decision about your care.
- You may discuss your questions or concerns regarding any information listed or discussed with our finance department at (203) 288-0414 or contact your insurance provider directly.
- We may help you to use any other insurance that you might have; however, your insurance company does not require us to do so.

By initialing and signing page one of this policy packet, I have approved the Case Management Services as listed above. I will be asked to pay when services are rendered. I am responsible for payment, but I can submit my statement to my insurance by direct contact with the company. If my insurance does pay, you will refund any payment made by me, less co-pays or deductibles. These services are available via:

- Itemized & charged per event as noted above

- Packaged Case Management: $150.00 One Time Fee

If in the future I chose to change to a different payment option, service rendered will **not** be retro-active. Changes will take effect at the time of resigning this form; which then I understand my account will be updated to my option of choice.