Midwest Wellness Center Associates

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— OFFICE POLICY —

We are pleased to have this opportunity to work with you. We regard health care as a collaboration between patient, doctor, and the other members of your treatment team – including family members/significant other, primary care physician and therapist. Thank you for helping us work with you to create the quality care to which we are committed.

1. **Payment** in full is required at the time of service. (In order to facilitate your access to care, we have established "Preferred Provider" relationships with several insurers; for these patients, payments will be limited to applicable co-insurance/co-payments, deductibles, and fees for "non-covered services.") Every patient is required to provide a credit card "backup' which will be billed directly for all balances owed (including insurance payment beyond the 60 days mandated by Illinois law). Co-pays for visits are due at the time of service.

2. **In an emergency**, please call our crisis line at **773-296-5380** after hours. Please contact them immediately regarding any urgent medical/psychiatric issues, including significant side-effects of medication and any significant changes in behavior (including agitation, threats of suicide or violence, or new onset of hallucinations). However, if your situation becomes physically unsafe – whether due to a medical emergency such as unexplained or excessive bleeding, loss of consciousness, possible overdose, etc., or due to dangerous psychiatric symptoms — please call "**911**" directly so that those trained personnel can provide immediate professional emergency services.

   Telephone calls between appointments are reserved for such urgent medical/psychiatric issues. Other issues, including lab results, should be addressed at your next scheduled appointment unless you and your doctor have made arrangements otherwise. A service fee will be charged for calls on non-urgent issues. This fee is currently set at $15 for the first 5 minutes (or portion thereof), and $15 for each subsequent 5-minute increment incurred. These fees are not covered by health insurance contracts, and are the patient's personal responsibility.

3. **We have no objection to scheduling sessions** for consultation with family members (e.g., parents); however, if the identified patient is not him- or herself present, these fees may not be covered by health insurance contracts, and would then be the patient's/parents' personal responsibility.

4. **If you are unable to keep your scheduled appointment**, we need 24 hours (1 day) notice. Since we usually have a "waiting list" of patients wishing a sooner appointment; reasonable prior notice of cancellations permits us to better accommodate everyone's needs. Except in cases of family/medical emergency, appointments canceled with less than 24-hours notification will be charged a service fee of $60.00. "No Shows" where no contact is made with us before the scheduled time of the appointment will be assessed $100.00 for follow up appointments and $150 for psychiatric evaluations. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. Note that repeated "No Shows" (more than 3 in a calendar year) will result in the termination of our treatment relationship. We will, as a courtesy, attempt to contact you with an appointment "reminder" – usually a confidential phone call, text, or email depending on your set preference – within the week prior to your scheduled appointments; however, scheduling and, when necessary, timely rescheduling, remain the patient's privilege and responsibility.

5. **Prescriptions** will be refilled at each appointment, following re-evaluation of your condition and medical needs, and we will provide you with at least sufficient medication and refills to extend until our scheduled next appointment. In the event of an emergency (*e.g.*, while out of town or on weekends) small amounts of medication may be available directly from a pharmacist for up to 72 hours.

Between-session telephone refills not occasioned by emergency will be subject to a $25 fee (which is not reimbursable by your health plan coverage). If such a refill is needed, please have your pharmacy fax the refill request to our office at 630-541-8381 and we will attempt to respond the next business day.

Ritalin, Focalin, Metadate, Daytrana, Concerta (methylphenidate), Dexedrine, Adderall (amphetamine salt), Vyvanse, and Benzodiazepine prescriptions are required by Illinois law to be handwritten (telephonic prescriptions and refills are not permitted), and expire 90 days following the prescription date. It is therefore imperative that patients fill these prescriptions promptly. Should the prescription expire, the expired prescription must be returned for our records, and a re-written prescription may then be obtained. The fee for such refills is $25 (which also is not reimbursable by your health plan coverage – again, this fee is waived in cases of rescheduling due to emergency). All fees must be paid prior to your next appointment.

6. **For review of past medical records and for report preparation**, there will be a service charge of $50 per 15-minute increment. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. (This does not apply to legal cases, which are billed at a separate rate.) This **does not** pertain to obtaining past records from other facilities/providers for our review if you are a new patient transferring services to us.

   For any forms or letters that need to be written between appointments, there will be a service charge of $25. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. All fees must be paid prior to your next appointment.

7. **We recognize that our patients (and their guardians) have the right to refuse treatment**, which includes the discontinuation of medications or psychotherapy. However, in order to responsibly and effectively serve you as your physicians, **we need to know of medication changes** (including discontinuation!) **in advance**. If communicating with your psychiatrist in advance regarding alteration/discontinuation of prescribed medications is for any reason unfeasible (for instance, the emergence of an intolerable side effect or medication reaction), please call our office so we may alert your doctor immediately. If this policy is in any way objectionable to you, please discuss these objections with your psychiatrist before consenting to the prescription of any medication.

   Your psychotherapy is also an important component of your medical treatment, and, again, we need to be aware of any problems occurring, including any significant interruptions, so that we may continue to responsibly and effectively serve you as your physicians. We regard termination of psychotherapy as a matter best managed by client and psychotherapist in the course of their therapeutic dialogue; however, on rare occasions disagreements may arise respecting the course of therapy. If you are considering discontinuing psychotherapy against your therapist's advice, please contact your psychiatrist before finalizing termination.

8. **Notice of Privacy Policies:** Confidentiality is your right, and our duty. The privacy of all records pertaining to your treatment will be maintained securely by us. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made) and to request amendments to these records, and we will make copies available to you upon your written request. We charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with us and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

9. Your active participation is essential to our ability to provide quality services to you while minimizing fee increases. **Please assist us** by taking responsibility for this participation in your medical care. Ways that you can help include:

   - Provide advance **written consent for release of information** to those with whom you wish us to work in your treatment – primary care physicians, school personnel, spouse/family members, therapists and other consultants. Consents can be found on our website and in your registration packets as well as at your providers offices.

   - Assist us to expedite receipt of **lab values** from clinical laboratories and your other doctors' offices, and submit **questionnaires** as recommended to your child's school if necessary.

   - Contact your **insurance** company in advance to verify benefits and/or "pre-certification".

   - If treatment is sought for a minor child of divorced or separated parents (or for any person whose **guardianship** has been settled by Order of Court), our office *must* have on file a copy of the divorce decree or other Court Order specifying the terms of custody, visitation and guardianship, particularly regarding guardianship for healthcare. We must receive consent in advance for our services (both evaluation and treatment) from a party legally authorized to give consent for healthcare services. Payments of fees to our office will be the sole responsibility of the parent or guardian signing here as "responsible person" notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party. (Reimbursement from any other such party – e.g., co-parent – to the payee for payments made to us must be arranged directly by the signing "responsible person;" our office cannot bill such third parties.)

Finally, we thank you for this opportunity to work together, and hope you will be as pleased with our services as we are in providing you with the best possible psychiatric care.

Thank you for understanding our Office Policy. If you have any questions, please do not hesitate to ask us– we are here to assist you.