SOUTH TEXAS TMS
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PSYCHIATRIST-PATIENT SERVICES AGREEMENT

Welcome to South Texas TMS. The Psychiatrist-Patient Services Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. You may revoke this Agreement in writing at any time.

_____ **PSYCHIATRIC SERVICES:** Initial evaluation typically lasts 60 minutes to determine a medical diagnosis and treatment plan. Follow-up appointments range from 15 to 50 minutes for medication management and psychotherapy session. Dr. Salinas-Garcia will discuss your treatment needs and schedule follow-up visits accordingly.

_____ You are responsible to remember and keep your appointment regardless if you receive a reminder or not. Please provide the office with a current working cell number and email address to eliminate communication issues. All **courtesy appointment reminders** and communication will be done by phone calls, email or text message. I agree to receive text messages by the office and understand that **standard text message fees may apply** depending on the phone carrier.

_____ Once an appointment is scheduled, you will be expected to pay for it, unless you **provide 24 hour in advance notice of cancellation**. For example, an appointment scheduled on Monday at 1:00 pm the appointment needs to be canceled by the previous Friday at 1:00 pm in order to avoid a missed appointment charge. Insurance companies do not provide reimbursement for any missed appointments.

_____ **In the event of late cancellation or no show, you are responsible for the fee of $300. 00**

_____ The No Show Fee must be paid in full or payment arrangements must be made before another follow up appointment is scheduled. **More than 3 late cancellations or No Shows in 1 year will result in the termination of care.**

_____ A **$75 deposit** is required to hold a TMS Consult appointment. This will be fully refunded to you if you cancel the appointment more than 48 hours ahead of time. A cancellation with less than 48 hours notice, the deposit will not be refunded.

_____ **COURT COSTS**: It is very disruptive to the office routine and unfair to other patients when I am ordered to testify in proceedings. If you are considering involving me in any legal procedures, please consider the following:

_____ Any request or subpoena for court appearance requires an immediate $3000 retainer, acceptable only by credit card, cash or cashier's/bank check or money order. I charge $300 per hour with a one-day (ten hour) minimum for any trial, such that your minimum charge will be $3000 per any part of a day, even if I am only on call for the trial and am not pulled to testify.

_____ **TELEPHONE CONSULTATION & FORMS COMPLETION FEES:** I will begin charging a fee for lengthy telephone calls and/or emails relating to your care, which will not be covered by your insurance. I also charge a $50 fee to complete forms and to write reports and/or letters to include FMLA and Disability and $25 for Jury Duty and/or any other letters that requires our letterhead ($10 fee for addendums to letters already written). You will be invoiced for these charges and you are responsible for paying these charges.

_____ **PRESCRIPTION FEES:** There is a <u>$10 fee per prescription</u> for all lost scripts. There is no charge for prescriptions or refills that are accomplished at your scheduled appointments. Please try to request all prescriptions <u>at least five days in advance</u>.

_____ **RETURNED CHECKS:** A $35 fee will be charged by my office for all non-sufficient funds. Your check will be re-deposited after 2 days unless you notify my office otherwise.

_____ **CONTACTING ME:** The office is usually open Monday through Friday, by appointments. We may close the office for holidays and vacations, and this will be stated on the telephone voicemail greeting. After hours and/or when the office is closed, you may leave a message on the voicemail for routine, non-urgent matters, and your call will be returned during normal business hours. For urgent matters, you may reach Dr. Salinas on their after-hours phone number.

_____ **CONFIDENTIALITY:** All information and records you provide will be kept confidential and will be held in accordance withTexas state laws regarding the confidentiality of such records and information. However, records and/or information may be released regardless of consent under the following circumstances: (**1**) I must report all cases of physical and/or sexual abuse of minors or the elderly to the appropriate agency. (**2**) I must report all cases in which there exists a danger to self or others to the appropriate agency. (**3**) With your approval, I will release information to insurance companies in order to process medical claims and to authorize payment. (**4**)In the event that you need emergency services, medical personnel will be contacted including possible hospitalization. (**5**) If you become involved in specific legal proceedings, the courts may subpoena information concerning your treatment.

_____ **PROFESSIONAL RECORDS:** I maintain PHI about you in your clinical record, except in unusual circumstances that involve danger to yourself and/or others. You may examine and/or receive a copy of your clinical record if you request it in writing. I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I will charge a copying fee of $50.00. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request. Insurance companies can request and receive a copy of your clinical record.

_____ **PATIENT RIGHTS:** HIPAA provides you with rights with regard to your clinical record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records, and the right to request a paper copy of this Agreement.

_____ **BILLING AND PAYMENTS:** You are expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires other arrangements. All charges are your responsibility whether the insurance company pays or does not pay. Not all services are covered benefit in all contracts. Fees for these services along with unmet deductibles and copayments are due at the time of appointment. All balances older than 90 days may be subject to collection placement and collection fees which

will be charged to the responsible party. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our billing personnel, so that we can assist you in a management of your account with a payment plan.

_____ **INSURANCE REIMBURSEMENT:** If you have health insurance, I can fill out forms and provide you with assistance to help you receive your benefits. **Please note that you, not your insurance company, are responsible for full payment of my fees. If your insurance changes, you are responsible for notifying my office of this change in writing.** It is important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, you may choose to contact your plan administrator. Your contract with your health insurance company requires that I provide the health insurance company information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes, I am required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. In some cases, the insurance companies may share clinical information with a national medical information databank. I can provide you with a copy of any report I submit, at your request. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You may request a copy of this document.

Patient's Name (Please Print)_____Date:_____

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Patient's Signature (or Parent's or Guardian's Signature, for minors)