Crescent City Psychiatric, LLC

Consent to Evaluate and Treat

Date: _____

Patient_____Age:_____Date of Birth: _____

Social Security Number: _____

Gender: Male____ Female____

Phone number you would like to be contacted at: _____

Home Address: _____

City, State, Zip Code: _____

Email: _____

Pharmacy Name:_____Pharmacy Number: _____

How did you hear about us? Friend____ Family member____ Health care provider____

Internet Search___Other (please explain):_____

Please complete the following if the person responsible for payment is someone other than patient:

Name: _____

Relationship to patient: _____

Gender: Male____Female_____

Address (if different from the patient)_____

City, State, Zip Code: _____

Phone number you would like to be contacted at: _____

*****I authorize Crescent City Psychiatric to evaluate and treat:**

Patient Name:_____Date of Birth: _____

Signature of Patient:_____Date: _____

Crescent City Psychiatric, LLC

Notice of Patient Rights and Responsibilities

As a patient at Crescent City Psychiatric, you have the right to privacy and confidentiality regarding your health care. Thank you for giving me the opportunity to best serve your needs, and for allowing me to provide mental health services to you.

As a patient, you have the following rights:

1) The Right to Privacy and Confidentiality: All records and communication regarding your health information will be kept secure and be kept confidential in compliance with state and federal laws. Under state and federal, there may times when confidentiality may have to be broken and health information disclosed to certain parties. This includes cases of those who pose a danger to themselves or others, domestic violence, suspected abuse or neglect. We may also be mandated to report your health information by court order, or when it is necessary to prevent or lessen a series imminent threat to the health or safety of a person or public. With your authorization, we may also use and disclose your health information to insurance or managed care companies for payment of services. This may include submitting a diagnoses which describes a mental disorder that you or your child may meet the criteria for under the DSM-IV-TR or DSM-V. This information may be accessed via paper claims or electronic claims that I submit directly to your insurance company or may be stored in an electronic based system that other insurance companies may access when we apply for a certain insurance panel. If you do not wish to release this information, you must then pay cash for services rendered.
2) The Right to Medical Records: You may request a copy of your medical records pertaining to your treatment. A reasonable copy fee may be applied.
3) The Right to Account Information: You may request an accounting of certain disclosures that is made of your health information. A reasonable fee may be applied.
4) The Right to Clear Instructions and Up-to-date Information: We will make it a priority to clearly explain you or your child's diagnosis, discuss prognosis, discuss treatment options, discuss the of risks and benefits of treatment(s), discuss the nature and purpose of certain tests and procedures, prescribe therapy or medications, order laboratory tests, provide the need for follow-up visits, recommend other mental health or medical professionals as referrals, and discuss any additional measures to achieve desired outcomes for you or your child's diagnoses.
5) The Right to Accept or Refuse Treatment Recommendations
6) The Right to Seek Additional Professional Opinions
7) The Right to a Safe Environment
8) The Right to Professionalism and Courtesy
9) The Right to Continuation of care—Please note that we will refer you to another practicing mental health provider, mental health clinic/hospital, or emergency service(s) in the event that a provider at Crescent City Psychiatric is not available to treat you or no longer available to treat you upon termination of care

As a patient, you have the following responsibilities:

1) Contact your treatment provider for any serious situation that arises, even after normal office hours
2) Provide correct, and complete information about your health
3) Follow the treatment plan to achieve your treatment goals
4) Advise your treatment provider of any changes in your health condition
5) Be respectful the rights of other patients and building/office personnel
6) Arrive for your scheduled appointment on time and call the office if you are unable to make your appointment
7) Meet the financial obligations for your care as soon as possible

*****By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information.**

Patient Name:_____ Date of Birth: _____

Signature of Patient:_____ Date: _____

Crescent City Psychiatric, LLC

Financial Policy Agreement and Appointment Adherence Agreement

1. We do not bill a patient's insurance plan. If a patient's insurance covers all or a portion on office visit with your provider, our staff can give you a form after each visit that you can submit to your insurance company for possible reimbursement. All patients are required to pay the session fee in full for the service rendered at the time of the appointment.
2. Fees: Fees/Rates for each session will be determined between provider and patient before the start of the first session. Additional fees for written letters, disability forms, work/school accommodations, and consults in between appointments may also be assessed and charged based on an hourly rate determined by your provider. Refunds will not be issued under any circumstances.
3. Cancelation policy: Patients will be charged **$90 when less than a 48 business hours' notice** is given by the patient. Normal business hours are Monday through Thursday, 9am to 3pm. **Reminder calls and emails to our patients are offered as a courtesy only.** Patients should leave a voicemail or email info@crescentcitypsychiatric.com to cancel appointments.
4. Please note that directly responding to appointment reminder texts or emails will not be received by our staff and should not be considered as a form of cancelation.
5. We have the right to discharge clients at any time. However, patients who miss more 2 or more appointments without 48 hour notification, or are 10 minutes or more late for their scheduled appointments on 2 or more occasions, will be discharged automatically and mailed a written letter of the notification. Medications may be refilled for a one month supply if appropriate.
6. Questions: You are encouraged to call our office if there are any questions about this information. If at any time during the treatment of the patient and financial problems arise, you are encouraged to speak with our office.
7. Payment for services rendered can be made by cash, card, or checks written out to Crescent City Psychiatric, LLC.
8. Checks that are not cleared by the bank for any reason will be assessed a $30 service charge. You will be asked to bring cash, certified check or money order to cover the amount of the check and the service fee. All bad checks written at the office are subject to collection action and will be prosecuted by Jefferson Parish District Attorney's office.

*****By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information.**

Patient Name:_____ Date of Birth: _____

Signature of Patient:_____ Date: _____

Crescent City Psychiatric, LLC

Prescription Medication Policy

1. If a patient has questions, concerns, adverse effects from a medication, it is the patient's responsibility to notify our office with any concerns. If patient receives our voicemail, a message should be left including the patient's name, DOB, and the question or concern that patient is having. Our staff will then return your call ASAP. If patient is having an emergency, patient is advised to call 911 or visit their nearest urgent care or emergency room.
2. Patient should call 911 or visit their local emergency room for an emergency. Examples of an emergency include but are not limited to: patient having thoughts of hurting self or others, patient concerned about worsening of symptoms, patient concerned of having or experiences effects from abruptly stopping their medication at any time during treatment or after treatment has been terminated.
3. A patient should seek care from an urgent care, emergency room, or their general practitioner in the event where the patient expects to be without their prescribed medication, and he or she feels they cannot wait until their next scheduled appointment with Crescent City Psychiatric to obtain their prescribed medication.
4. Crescent City Psychiatric in under no obligation to continue prescription medications and may terminate care if the patient does not follow the recommended treatment plan and/ or adjusts his or her medications on their own at any time without consulting with Crescent City Psychiatric.
5. Patients with insurance are responsible for knowing which medications may or may not be covered by their insurance plan.
6. Due to the high volume of requests, our providers are unable to assist with Prior Authorization requests for medications. Patients are expected to know what their insurance plan covers for medications, and if a medication prescribed is not covered by insurance, patients are expected to pay out of pocket for their medication or request that their provider recommend an alternate medication that their insurance may cover within their insurance plan.
7. Patient acknowledges that availability of appointments is limited, and patient is solely responsible for scheduling their follow-up appointments in a timely manner to ensure he/she will have enough medication to last until their next scheduled appointment ("timely manner" is defined as no longer than 24 business hours after being seen by their provider for an appointment).
8. Patient should email or leave a voicemail for refill requests. Patients areresponsible for knowing the medication name, dose, and directions of their medication. Pharmacy refill requests will be denied until we first hear from the patient that a refill is being requested. After an officialrequest is made, please allow 3 business days for staff authorize the refill.
9. Patient must have had at least one follow-up visit with their provider at Crescent City Psychiatric to assess the response and possible side effects of the medication before a refill will be authorized.
10. A refill may be authorized for a non-controlled substance for 30 days for patients who missed their appointment due to an illness or emergency ONLY if the patient has already seen a provider at Crescent City Psychiatric for at least ONE follow-up visit in which the provider has been able to assess the response of prescribed medication and thus has continued the prescribed medication.

*****By signing below, you agree that you have read and understand the Prescription Medication Policy**

Patient Name:_____ Date of Birth: _____

Signature of Patient:_____ Date: _____

Crescent City Psychiatric, LLC
Telemedicine Consent

1. I understand that my health care provider wishes me to engage in a telemedicine consultation

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:
- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

***Patient Name_____

***Patient Signature_____Date: _____

Credit Card Consent Policy Form

I, the undersigned, authorize Crescent City Psychiatric to keep my signature on file and to charge my credit/debit card account as indicated below:

A charge to the credit/debit card will be made under the following circumstances:

1. Missed appointments
2. Cancellations made less than 48 hours from time of a scheduled appointment
3. Payments made at the time service is rendered

(Initial)_____I, the undersigned, understand that this form will be valid for the duration of my treatment with this office unless I cancel through written notice to Crescent City Psychiatric, 1 Galleria Blvd #1900, Metairie, LA 70001 or via email at info@crescentcitypsychitric.com.

(Initial)_____I understand that refunds will not be issued under any circumstance, unless my card is charged by mistake or overcharged.

(Initial)_____I understand that there is a **missed appointment/late cancelation fee of $90,** and that in order to cancel my appointment without being charged the full session fee, I must leave a voicemail with Crescent City Psychiatric at 985-249-1322 or email info@crescentcitypsychiatric.com no later than 48 business hours prior to my scheduled appointment time.

_____ _____

Patient Name Cardholder Name

Card Type: Visa_____ MasterCard_____ Discover_____ Amex_____

Credit Card Number_____

Name as appears on Card _____

Client Name (If different from name on card) _____

Expiration Date (mm/yyyy) _____

Zip Code_____

Security Code (Usually the 3 digit ID on the back of card, 4 digits if American Express)_____

_____ _____

Cardholder Signature Date