FAMILY WELLNESS CENTER AND SOUTH TEXAS TMS
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PSYCHIATRIST-PATIENT SERVICES AGREEMENT

Welcome to the Family Wellness Center and 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. Once an appointment is scheduled, you will be expected to pay for it, unless you provide at least one business day's advance notice of cancellation. For example, an appointment for Monday needs to be cancelled before close of business on the Friday before, in order to avoid a missed appointment charge. Insurance companies do not provide reimbursement for no-show appointments and/or appointments that you do not cancel with sufficient notice. A missed appointment fee of **$125** will be charged for an appointment not cancelled with sufficient notice or for a no-show appointment. As a courtesy, we try and confirm upcoming appointments by phone. Please provide us with phone numbers that you regularly answer and that you answer during the business day. You are responsible for appointments that you schedule.

MINORS & PARENTS: I see patients starting at age 5. I expect adults to accompany their children to appointments. Please do not leave your children unattended in the reception area, as I cannot be responsible for their well-being. Payment for services rendered to minors is the responsibility of the parent/guardian.

TELEPHONE CONSULTATION & FORMS COMPLETION FEES: I charge a fee for telephone calls relating to your care. Additionally, I charge a **$25** fee to complete forms and to write reports or letters to include FMLA, Jury Duty or any other letters that requires our letterhead. You will be invoiced for these charges and you are responsible for paying these charges.

PRESCRIPTION FEES: There is a **$10 fee per prescription** for prescriptions and refills that are requested at times other than during a scheduled appointment or for lost scripts. There is no charge for prescriptions or refills accomplished at scheduled appointments. Please try to request prescriptions at least one week in advance.

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 appointment. 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 the after-hours phone number.

CONFIDENTIALITY: All information and records you provide will be kept confidential and will be held in accordance with Texas 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. If I am an in-network provider for your insurance, I will collect the portion of the fee that the insurance does not cover. Payment schedules for other professional services will be agreed to when they are requested. If you are experiencing difficulty meeting your financial obligations for any reason, please speak with my office manager about your concerns. I will try to work out an arrangement that will make it possible for you to meet your obligations. However, if your account is not paid in a timely manner and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment.

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)