PPG

PROGENY PSYCHIATRIC GROUP
PROGENY PSYCHIATRIC CLINIC

Welcome to Progeny Psychiatric Clinic!

This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician or our front staff. Your signature or initial at the bottom of each page indicates that you understand the information and agree to each section.

If you change insurances, legal names, mailing address, or contact information **please notify** the front desk as soon as possible.

CLINIC INFO:

Our main line: (949) 722 – 7118
Irvine fax: (949) 579- 9102
Huntington Beach Fax: (657) 329-0237
Dana Point Fax: (949) 493-0669
Anaheim Hills Fax: (714) 485-2111

*The main line will give you options for each of the clinics. Otherwise, you may use your site location directly via their direct line.

Our billing department: MIS BILLING (949) 955 - 2101

All this information & additional resources can be found on our website www.progenyclinic.com.

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Consents

INFORMED CONSENT

I understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without my written permission. (*This release is available in our office or may be completed with any individual whom you wish to give such access, and then provided to us*.) The only exceptions to this policy are rare situations in which you are required by law to release information with or without my permission. These are: 1) if there is evidence of physical and/or sexual abuse of children or abuse to the elderly; 2) if you judge that I am in danger of harming myself or another individual; and 3) if my records are subpoenaed by the court. In the rare event of any of these situations, you would attempt to discuss your intentions with me before an action is taken, and you would limit disclosure of confidential information to the minimum necessary to ensure safety.

PSYCHIATRIC EVALUATION CONSENT

By my signature below, I acknowledge that I consent to a psychological evaluation by Progeny Psychiatric Clinic, that I have been informed of the policies regarding evaluations at the clinic and have read the 5 pages consent form as well the policies regarding late/cancellation and missed appointments; and I agree to all of the payment arrangements outlined in this form. I fully understand my rights and obligations as a client at the PPG and I freely agree to this assessment.

_____	_____	_____
Signature	Date	(Please print name)
_____	_____	_____
Signature/Relationship (If client is under age 18)	Date	(Please print name)

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Confidentiality Agreements

CONFIDENTIALITY AGREEMENT

Privacy Policy

Confidentiality is the legal right to privacy for all patients who receive psychiatric and psychological services. Such as, all personal information presented to this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. ***However, there are exceptions to confidentiality.*** *Please be advised, all information discussed in this office will remain confidential except under the following conditions set forth in this agreement:*

- When you consent in writing for Progeny Psychiatric Clinic to release and disclose information to another entity or person (as detailed on the authorization to release PHI).
- A breach of confidentiality is required or permitted by law. Examples include instances in which Progeny Psychiatric Clinic has a reasonable suspicion of child abuse, elder/dependent adult abuse, dangerousness toward self or others, and other matters subject to law.
- Progeny Psychiatric Clinic in their discretion decide to obtain consultation on your case with a colleague or legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your billing being turned over to a collection agency or submitted to small claims court.
- Upon notification of a social service agency case, wherein all information shared with Pacific Psychiatric Group will be conveyed to the assigned social worker and/or other SSA representative and agents.
- If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody case you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. PPG may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders. We cannot give you legal advice as to what action may or may not waive your privilege.
- Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.

NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY

If your child participated in treatment, it is important to allow him/her to develop a confidential relationship with his/her psychiatrist and/or therapist. As such, you understand that most personal information that your child discusses with his/her therapist will not ordinarily be shared with you. Rather your child's doctor will provide you with general summaries of your child's progress without private details. This office is committed to informing you about unusual or dangerous symptoms or behaviors (such as violence, child abuse, self-abuse, suicidality, or intentions to harm others, harm oneself, drive while intoxicated, etc.)

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Clinic Policies

APPOINTMENT POLICIES

Initial evaluations, assessments and full sessions are generally about 30 to 60 minutes in duration. Subsequent follow-up session ranges from 15-30 minutes in duration. Medication management sessions are about 15 minutes in duration, based on a case-to-case basis. However, these sessions may require more time than expected. All paperwork and submission of co-pay must be rendered before the beginning of the session. Please arrive 15 minutes before your scheduled appointment for ease of operations. Please respect time guidelines so that the next patient waiting is not affected. If returning after 1 year, you will be considered a new patient and must be re-evaluated.

URGENT/EMERGENCY SERVICES

We are an outpatient clinic and are not equipped to handle emergency medical services. We want to ensure that you are given proper care when you need it. For this reason, we recommend that if you experience any critical adverse reaction or present current suicidal ideation, please contact 911 or visit the nearest emergency room. After you have received urgent care, please follow up with your outpatient provider to discuss any changes made at the hospital (they will also recommend this before discharge).

24-HOUR CANCELLATION POLICY & LATE ARRIVALS

Cancellation & late arrival phone number: 949-722-7118
Please store this number where it will be convenient for you if you need it.

LATE ARRIVALS:
If you arrive late, it is the providers discretion to see you on that day or request to reschedule for a future date. Calling in to notify of late arrival does not guarantee you will be seen as we do not have a grace period.

ABOUT THE 24-HOUR CANCELLATION POLICY:
All appointment cancellations or changes must be made within 24 hours, or the patient may accrue a no show fee.

Reason for this policy: Notifying of your intention to cancel or reschedule 24 hours in advance gives an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. As much advance notice as possible is really appreciated.

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**If you simply do not show up for a scheduled appointment, you will be charged for the missed appointment.
**An email or voicemail notification given within the time frame is acceptable as proper notification.

Because it is illegal to bill your insurance company for a missed appointment, you will be responsible for the full fee for the missed session out-of-pocket (resulting in a much higher payment than you may have paid for a kept appointment). The hourly cash-rate will vary per/hour per provider:

This cancellation policy is standard in the medical and mental health fields and will be strictly enforced. On occasion, there will be understandable reasons for missing appointments, but exceptions to this policy will be rare. If you have three (3) no shows within a calendar year, we will discontinue treatment services.

REFILL POLICIES

- You are responsible to notify the office at the time of your appointment if you are running out of medication so that we can avoid medication shortages.
- If you have mail-in series, you are responsible to mail the forms and prescriptions after we fill them out to avoid any confusion.
- Medication refills must be taken care of during your appointment, under unforeseen circumstances if you run out of medicines; please contact the office during regular business hours. We will be happy to refill your non-controlled medications if you have a scheduled follow-up appointment or will schedule you with the next available provider.
- Controlled lost/stolen prescriptions may require a police report and will only be refilled if clinically safe.
- Refills do not guarantee medication coverage, please speak to your pharmacy regarding coverage

FORMS OF COMMUNICATION

- You may contact our offices via: phone, email, online form submissions, yelp messaging, or voicemail.
- Please allow our front staff up to two business days to reply to your emails.
- Providers may have their own turn around time for responding to emails, please discuss this with your provider.
- Voicemails are returned within 1 business day. Please make sure to leave a full message so that we able to properly assist you.
- Our text and email reminders will be sent to the number and/or email you provided. These reminders are complimentary, please make sure to also keep note of your appointment. If at any time you would like to remove them, please advise our front staff.

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FORMS/PAPERWORK

Any requested forms must be discussed with your provider first. It is up to the provider's discretion to agree to forms, letters, and disability paperwork. Our general turnaround time on paperwork is 5 to 7 business days (up to 14 business days on some forms) but can vary in unforeseen circumstances. Please make sure to bring in your requests within a timely manner.

PRIOR AUTHORIZATION

Our office may submit PAS, for medications. It is the patient responsibility to make sure we have the most updated insurance, contact, and billing information so that we may submit it to the proper plan. Prior authorization approvals are not guaranteed and are dependent on your insurance. Prior authorizations may take 5 to 7 business days to complete, from the day we are notified of the request.

SWITCHING PROVIDERS

You can see another provider within our clinic if your provider is unavailable. This is not considered switching providers. Switching providers means you would like to stop care with your current provider and start your care with another. Our goal is for you to have an established relationship and continued care. We will limit switching providers after 2 times. When switching providers, it must be for a reason other than not agreeing to treatment plan (requesting particular medications that a provider declined, requesting increased dosages that a provider declined, requesting only controlled medications that a provider declines..etc.) Medications and care provided will be based on your provider's evaluation and **only** given when medically appropriate. If you do not agree to your treatment plan, we may ask that you seek a second opinion, outside of our clinic.

PATIENT TERMINATION

Our mission is to provide quality care for all of our existing patients. The collaborative relationship between our office and our patients is essential to the care received and any damage to said collaboration may be detrimental. Please see below for possible reasons of discharge.

- **Noncompliant to treatment**
- **Failure to adhere to attendance policy**
- **Failure to adhere to clinic policies**
- **Aggressive or violent behavior** **_____INITIAL**

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FINANCIAL TERMS

Please note, you are responsible for obtaining prior authorization for treatment from your insurance company. In addition, you are responsible for all co-pays and insurance services when rendered. Furthermore, I understand I am responsible for charges not covered by my insurance. I further agree if at any time during my treatment, I become aware that I am ineligible for insurance coverage, I will notify PPG immediately, I understand I will be financially responsible for 100% of the billed charges. Lastly, I agree to notify PPG of changes to my personal and or insurance information, we keep a current credit card on file.

Medicare Patients, by signing below I agree to pay 20% of the Initial Visit, all follow-up visits, and any deductible amount.

OUR BILLING DEPARTMENT IS MIS BILLING, YOU MAY CONTACT THEM AT # 949-955-2101

PAYMENT TERMS AND UNCOVERED SERVICES

I understand I will be charged the regular hourly rate of $150-$400 for services required outside of the treatment sessions. These services include consultations with other professionals. I will be charged a fee for conservatorship, petitions, disability forms, or any letter that is required for medical leave.

Please be advised, should it become necessary for PPG to employ an attorney to enforce any of these conditions hereof, I understand I will pay any/and all expenses so incurred included reasonable attorney fees.

Types of Payment. Services are payable in advance of each appointment. Please make checks payable to Progeny Psychiatric Clinic. Also, for your convenience, you may pay by cash or credit card. Please note, receipts will only be given by request at the beginning of your appointment.

Prompt Payment. Balances not paid within 30 days are considered "PAST DUE". Balances not paid within 60 days may be sent to our collections agency or pursed through small claims court. IF you are not able to make a full payment, you agree to make regular payments no less than $100.00 until the balance is paid in full.

Insurance Claims. Please note, you are required to pay for all services rendered not covered by your insurance carrier.

RETURN CHECK FEE. Returned check fee is $25.00. If for any reason a check is returned without having been paid, patient will pay an additional fifty dollars ($50.00) as a non-sufficient fund's payment.

RIGHT TO END THERAPY. You have the right to end therapy at any time with no obligation expect to pay for completed services.

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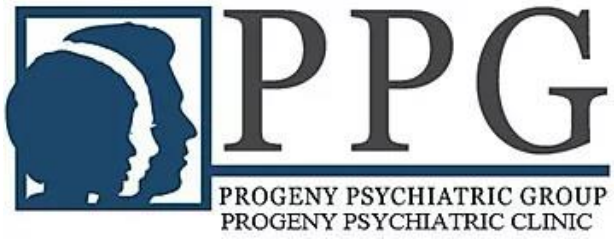
FINANCIAL POLICIES

Professional services and rates: Our professional services and rates are as follows:

Professional Services	Times	Rates MD/DO	Rates for NP/ PhD	Rates for LCSW/LMFT
Initial Visit	30-40 min 60 min Therapy	$400	$300	$150
Follow Up	15-20 min 60 Min	$250	$175	$150
Missed Appointments	No Call/No Show	$50	$50	$100

Forms, letters, and other non specific

Forms, Report Writing (Treatment summaries, disability, letters, etc.) Conservatorship Forms	Prorated	$50 *Varies by document	$50 *Varies by document	$50 *Varies by document
Court-Related Services: (any court-related services, including evaluation, depositions, conferencing, testimony, preparation, standby and travel time, reports to be used for legal purposes etc.)	Prorated Half-Day minimum for court attendance or standby status. Retainer required in advance. RETAINER FEE To be paid prior to court Date.	$800 (Varies by Case) $2000 (Varies by Case)	$400 (Varies by Case) $1000 (Varies by Case)	$400 (Varies by Case) $1000 (Varies by Case)



CREDIT CARD AUTHORIZATION (OPTIONAL/ REQUIRED FOR TELEPSYCH)

I,_____, authorize Progeny Psychiatric Clinic, to charge my credit card for additional services provided to patient,_____, for services not paid by insurance carrier and which are considered concierge services as noted under payment terms and uncovered services. Charges to this credit card may include but are not limited to office visit, phones sessions, paperwork, and late cancellation and no-shows. I understand my credit card will be charged for these services and I have reviewed Progeny Psychiatric Clinic 24-hour cancellation policy.

Card Type: _____Visa _____MasterCard _____Discover _____AMEX

Card Number: _____

Security Number on Card: _____

Expiration Date: _____

Signature:_____Date: _____

Acknowledgement of Receipt of the HIPAA Notice of Privacy Practice

With my signature below, I acknowledge that I have received this HIPAA Notice of Privacy Practices.

Patient name, please print: _____

_____ _____

Signature Date

If the signature is not from the patient, please explain nature of relationship or guardianship:

_____