

Old Towne Counseling & Wellness

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Informed Consent and Service Terms

Please read the following document in its entirety. Your signature at the end of this document indicates that you have read and agree to all terms below. If this document is executed by an individual other than the Patient identified below, any such individual is referred to hereinafter as the "Agent") and the Agent agrees to the following terms on behalf of the Patient and individually.

The undersigned does voluntarily consent to treatment of the Patient identified below by: Olivia Reichenbacker, PMHNP-BC (the "Provider")

General:

The Patient and any Agent each understand and agree:

- That no guarantees are being made as to the results of evaluation or treatment.
- The Patient must be an active participant in treatment, and the Patient and any Agent must provide accurate and complete information about symptoms and history of the Patient.
- The Provider does not accept or participate in insurance. Services provided are self-pay (fee for service) and payment is due in full at the time of service.
- The Patient and any Agent has received and reviewed a copy of the Notice of Privacy Practices.
- The Provider may consult with associates and other health care providers at times as the Provider may deem clinically advisable and the Provider is fully authorized to collaborate with associates and other health care providers regarding the Patient's care.
- While the Provider is out of the office or otherwise unavailable, the Patient may receive care from health care providers associated with Old Towne Counseling and/or others and this documents consent of the Patient to such treatment.
- The Provider and associated staff are hereby authorized to release any information necessary to process any insurance claims including, without limitation, preauthorization for medications.
- The Provider, or associated support staff, will typically undertake to return calls within 48 business hours, but neither the Provider nor support staff guarantee any particular response times. If the Patient experiences an emergency, the Patient or Agent should follow the guidelines under the Emergency Policy below. If a response is required sooner than 48 business hours, or no response is received from the Provider or support staff within the required time, the Patient and/or Agent will make other arrangements. See Emergency Policy below.

Appointments:

The Patient and any Agent each understand and agree:

- Cancelation Policy: In order to cancel a scheduled appointment, the Provider must be given notice at least 24 hours' notice before the scheduled appointment time. The Patient and any responsible party will be charged and agree to pay the full fee of the appointment if an appointment is cancelled on less than 24 hours' notice or if the Patient fails to show up on time for the appointment.
- If the Patient arrives more than 10 minutes late for an appointment, the Provider may not be able to or may decline to see the Patient that day and the Patient and any responsible party may be charged for and agree to pay the full fee for the appointment. Accordingly, the Patient will arrive a few minutes early for each appointment to check-in.
- The Provider may require that you reschedule your appointment if payment cannot be made in full at time of service.
- All balances must be paid prior to scheduling the next appointment for the Patient. This includes billed charges such as those for no shows, late cancellations, completion of forms/letters, phone calls, etc.
- For calls regarding treatment or medication issues lasting more than 5 minutes, the Patient and any responsible party will be charged and agree to pay a fee at the Provider's regular hourly rate as modified from time to time (currently, \$200 per hour), prorated to reflect actual time spent by the Provider.

Medication Policies:

The Patient and any Agent each understand and agree:

- Medication Refills: The Provider will typically undertake to respond to a medication refill request within 48 business hours, but neither the Provider nor support staff guarantee any particular response times. Refills cannot be guaranteed on a Friday, and will not be completed on weekends or holidays. The Provider will typically undertake to respond to other questions regarding medication issues within 48 business hours, but response times are not guaranteed.
- The Patient and any Agent are each responsible for managing the Patient's prescriptions. The Patient and any Agent agree to make all arrangements for medications at least 48 business hours before any medications are expended (i.e. at least 48 hours before the Patient runs out of medicine).
- Refill Requests Between Appointments: In addition to any other fees for missed or cancelled appointments, the Patient and any responsible party will be charged and agree to pay a \$15 fee for each refill request made when an appointment has been missed or canceled.
- There is no guarantee that the Provider will approve a refill if requested between appointments or that any refill prescription will be issued within any particular time.
- The Provider may limit medication refills to one refill between appointments, and the Provider may decline to issue a refill prescription in the Provider's discretion. The Patient and any Agent has been advised to plan ahead to schedule an appointment before running out of medication.
- Unless approved by the Provider, no changes to medication will be made outside of scheduled appointments.
- Controlled substances (Schedules II through V) may require a hard copy prescription for some pharmacies, and will not be authorized to fill early, no matter what the reason (lost or stolen prescription, taking more than prescribed, etc.).
- If the Patient believes a dose increase or a change in a controlled substance may be necessary, the Patient must be seen for an office appointment before the Provider will approve any such changes so the Provider can assess whether the change is appropriate for the Patient's clinical condition and health. There is no guarantee that dosing or frequency changes will be made.

- Prescription Monitoring Program: I understand that the Provider actively participates in the Prescription Monitoring Program and, by law, will access information about the Patient and/or report information about the Patient, as applicable.
- If the Patient has not attended an appointment for more than 7 months, prior to issuing any prescription for a refill, the Provider may require that the Patient be scheduled for a new intake appointment.
- The Patient and any Agent will inform the Provider if the Patient is receiving, or plans to receive, psychiatric medications from another provider. The Provider may work with any new provider where the Patient's care is transitioned to a new provider.
- **Severe allergic reactions, other health problems or death may result if the Patient exceeds recommended dosages of medications prescribed by the Provider or fails to notify the Provider and any other providers of any and all medications prescribed for or taken by the Patient. The Patient and Agent agree to provide full, accurate and complete information to the Provider and any other providers regarding any and all medications prescribed for or taken by the Patient. Failure of the Patient and/or Agent to comply with this standard is grounds for termination of treatment by the Provider, in the Provider's sole discretion.**

Fees:

The Patient and any Agent each understand and agree:

- The Patient and any responsible party will be charged and agree to pay additional fees for the following services:
- Professional Forms: completion of forms for employment, school, return-to-work, disability, retirement, legal action, etc. The Provider typically requires at least 10 days to complete forms from the time of the request, but no response time is guaranteed. Fees will apply at the Provider's regular hourly rate as modified from time to time (currently, \$200 per hour), prorated to reflect actual time spent.
- Letters: Fees will apply at the Provider's regular hourly rate as modified from time to time (currently, \$200 per hour), billable in 15 minute increments and payment is due prior to completion of the letter. This includes, but is not limited to forms pertaining to insurance, employment, return-to-work status, school, disability, retirement, and legal action. The Provider typically requires at least 10 business days to complete letters from the time of the request, but no response time is guaranteed.
- Medical Records: are provided at a rate of \$0.50 for the first 50 pages and \$0.25 for each additional page, plus any postage costs if the records must be mailed, plus any applicable search fees. Medical records can take up to 10 days to complete from the time of the request. All requests for copies of medical records must be received in writing, dated and signed, and must include a reasonable description of the records sought.
- Subpoena for Witness: If the Provider is subpoenaed by the Patient or a third party, the minimum fee is \$1800, which covers up to 4 Billable Hours. If more than 4 Billable Hours are required, the fee is \$3600 per day. Billable Hours include preparation time, travel time, and time spent waiting, and testifying. Additional fees may be assessed if travel outside of a 50-mile radius is required. Payment in full is due 5 business days in advance of the scheduled hearing. This fee continues to apply when the Provider attends and is not called to testify, and also when court or the subpoena is canceled, withdrawn, quashed, continued, or rescheduled less than 3 business days prior to the scheduled date for any reason (e.g. weather, the case being settled outside of court, the judge canceling the day, etc.).
- If the Provider does not receive payment when due, the Patient and any responsible party will be charged and agree to pay interest at the rate of one and one half percent (1.5%) per month for each month or portion thereof beyond the due date for payment, as well as all collection costs (including, without limitation, attorney fees and court costs) incurred by the Provider and/or Old Towne Counseling for collection of such amounts.

Emergency Policy:

The Patient and any Agent each understand and agree:

- Neither the Provider nor Old Towne Counseling provides emergency services.
- If the Patient is experiencing a psychiatric emergency, a life threatening emergency, and/or medication side effect causing shortness of breath, heart problems, severe rash, or other life- threatening symptoms, please call 911 or go to your nearest emergency room.
- The Provider or support staff may be able to contact your medical provider regarding medication emergencies during established business hours, but this is not guaranteed, and generally will not be addressed outside of normal business hours.

Patient Rights/Discharge:

The Patient and any Agent each understand and agree:

- Non-voluntary discharge from treatment: The Provider and Old Towne Counseling may terminate the patient relationship via a non-voluntary discharge letter if any of the following occur:
- The Patient exhibits physical violence, physical or emotional intimidation, verbal abuse of any kind, and/or patients or family members carry weapons or engage in illegal acts of any kind.
- The Patient or family engage in abusive phone or email correspondence.
- The Patient refuses to comply with stipulated clinic rules, refuses to comply with treatment plans/recommendations, or does not make a payment in a timely manner.
- The Patient repeatedly cancels, late cancels, or no shows for appointments.
- Other cause deemed reasonable by the Provider and Old Towne Counseling in their sole discretion.
- A Patient may choose to terminate treatment at any time of their own accord. Termination of the relationship does not relieve the Patient or responsible parties for fees due.

I have read and understand the information in this document. I have been given the opportunity to ask questions about treatment and the foregoing terms and all questions have been answered to my satisfaction. My signature below indicates my informed consent to treatment by Olivia Reichenbacker, PMHNP-BC and agreement and approval of the other terms set forth above.

Print Patient Name: _____

Signature: _____

Name of Agent (If Signed by Individual Other than the Patient):

Date: ____/____/____