Hamzavi Psychiatry and Wellness Center PLLC

74 W. Long Lake Rd. Suite 100, Bloomfield Hills, MI 48304
Phone: (248) 731-7458 Fax: (248) 973-6068
www.hamzavipsychiatry.com

Welcome to Hamzavi Psychiatry and Wellness Center, PLLC (HPWC). We look forward to meeting with you. In order to provide the best care possible, please read through the attached forms, sign and initial where required, indicating your understanding and willingness to abide by the following practice policies:

OFFICE POLICIES

APPOINTMENTS

_____ We ask that you be on time for your appointments. We are mindful of your time and strive to keep to the scheduled times. We ask that you be patient and understanding if we are running behind schedule. We will always do our best to alert you ahead of time if we are running more than 30 minutes behind and will always give you the option to reschedule if necessary.

_____ Our cancellation policy is as follows: please cancel your appointment by phone at least 48 hours before your scheduled appointment time but no later than 24 hours. If you do not cancel your appointment in time or you do not show, you credit card on file will be charged a fee for the appointment (please see Fee schedule).

_____You will be asked to make an appointment in the event of a telephone encounter with your physician of greater than 5 minutes. We encourage you to keep your appointments to ensure you receive the best care.

PAYMENT FOR SERVICES

_____ I understand if I have BCBS PPO, Aetna PPO, Priority Health insurance coverage for treatment, HPWC will accept payment from the insurance company, but HPWC does not guarantee coverage or benefit amounts and holds me responsible for payment. Full payment for these services is expected upon receipt of insurance determination and/or prior to my next appointment.

_____ I understand if I am a self-pay patient that **payment is due at the time services are rendered**. My appointment may be rescheduled if payment cannot be made in full at the time of service or I have not contacted the office prior to my appointment to make alternate arrangements.

_____ I understand **all balances must be paid prior to my next scheduled appointment and/or prior to scheduling an appointment**. This includes but is not limited to billed charges such as insurance responsibility, fees for no shows, late cancellations, completion of forms and letters, prescription refills.

_____ I understand that if my account becomes delinquent, over 90 days old, HPWC may report the status of my account to a credit-reporting agency or agencies.

_____ I understand a $25 fee will be charged for all returned checks.

_____ I understand I am required to have a credit card authorization form on file with a valid credit card number included.

COMMUNICATION

_____ Our normal business hours are Monday through Friday, 9 am to 5 pm. We request all communication take place during these hours.

_____ Any and all communication by email between you and our office staff that contains information pertinent to your treatment is considered part of and will be included in your medical record.

EMERGENCY POLICY

_____ If you are experiencing a psychiatric emergency, a life-threatening emergency and/or medication side effects causing shortness of breath, heart problems, severe rash, or other life-threatening concerns, please call 911 or go to your nearest emergency room. It is not guaranteed that someone will be available to respond quickly outside of normal business hours. Medication management is managed during regular business hours only.

TERMINATION OF TREATMENT

_____I understand that I may be terminated from treatment non-voluntarily for the following reasons:

1. If I exhibit physical violence, engage in physical or emotional intimidation, make threats of any nature, engage in verbal abuse of any kind with any of the physicians, therapists, or staff, and/or carry weapons or engage in illegal acts of any kind at the practice. Abusive messages or phone correspondence may also be grounds for non-voluntary discharge.
2. If I refuse to comply with stipulated practice rules or refuse to comply with treatment plans/recommendations, or do not make a payment and/or payment arrangement in a timely manner.
3. If I repeatedly cancel, reschedule, or no show for appointments.
4. If I am judged to have symptoms that cannot be adequately treated with resources available at Hamzavi Psychiatry and Wellness Center, PLLC.

We will notify you of non-voluntary discharge from treatment via letter. In the case of non-voluntary discharge from treatment, we will provide you with recommendations of psychiatrists in the area. We will refill your medications for 30 days after the date of termination to ensure continuity of care. After 30 days, you will be discharged from the practice.

PRESCRIPTION REFILLS – ***PSYCHIATRY PATIENTS ONLY***

_____ In general, all refill requests should be made during scheduled appointment times. You will be supplied with enough medications to last until your next appointment. The psychiatrists require all patients taking medications to be seen a minimum of every three months in order to obtain prescription refills. If you have not had an appointment within three months (or as recommended at your last visit), or have no showed appointments, We will not be able to refill your prescription. You MUST have an appointment scheduled to request a refill.

_____ A $25 fee will be charged to your account for prescriptions needing to be refilled outside of appointments due to the time involved in reading through your chart, assessing the appropriateness of the refill, and contacting your pharmacy.

_____ Refill requests outside of an appointment time need to be requested by you via telephone call. We do NOT refill prescriptions from pharmacy requests. We have a 72-hour window of time to refill any prescriptions. We ask that you be mindful of when you are scheduled to run out of medication and call ahead with the medication name, dosage, and directions for use. You are responsible for managing your prescriptions.

_____ Prescriptions will only be refilled Monday-Friday. Prescriptions will not be refilled on holidays or weekends. Medication refills will not be guaranteed on Fridays.

_____ The maximum quantity of stimulant medication that may be dispensed is a 90-day supply. Even if you are stable on the medication, an evaluation of your progress needs to take place at least every three months. For this type of medication, refills cannot be called into a pharmacy and dosages will not be adjusted by telephone. If you need a dose increase or a change in a controlled substance that we have prescribed for you, you must come in for an office visit. However, this does not guarantee there will be a change in dose or frequency of dosing for the controlled substance.

_____ Prescriptions for controlled substances will not be refilled earlier than you are scheduled to run out of the prescription no matter what the reason. Reported lost or stolen prescriptions will not be refilled in the absence of a police report.

_____ We reserve the right to perform random urine or blood drug screening at any time while being treated with a controlled substance. Failure to comply with drug screening within 24 hours could be cause for dismal from the practice.

_____ If you do not attend an appointment for an excess of six months, your medications will not be refilled. You will need to be seen in the office for an appointment before any medications can be refilled.

I have read, initialed, and agree to abide by Hamzavi Psychiatry and Wellness Center, PLLC Office Policies listed above.

Patient Signature:_____ **Date:**_____

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Patient Name:_____ Date of Birth:_____

Emergency Contact: _____

Phone: _____ Relationship: _____

Fee Schedule Agreement

FEES FOR SELF-PAY PATIENTS (non-BCBS, non-Aetna, and non-Priority Health patients):

Initial Psychiatric Evaluation	90 minutes: $350.00	Therapy Initial Evaluation: 60 minutes: $180.00
Initial Psychiatric Evaluation	60 minutes: $300.00	
Additional time	30 minutes: $100.00	Therapy Follow-up Session: 60 minutes: $160.00
Follow-up/Medication Review	30 minutes: $150.00	
	45 minutes: $225.00	
	60 minutes: $300.00	

FEES FOR NO-SHOW OR LATE CANCELLATIONS (less than 48 business hours) – ALL PATIENTS

- First Missed or Late Cancellation Appointment - No charge
- Second Missed or Late Cancellation Appointment - $75.00
- Third or More Missed or Late Cancellation Appointment – Full Appointment Fee

MISCELLANEOUS FEES – ALL PATIENTS

- **Prescription Refill: $25.00**- if requesting refills outside of scheduled appointment times. Prescriptions are to be requested during follow-up appointments.
- **Paperwork Completion outside of appointment time (disability forms, work or school letters): $25.00** - Simple forms which can be completed by office staff will be provided free of charge.)

Required Authorization for Recurring Credit Card Charges

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy or psychiatry sessions. You agree that no prior notification is necessary unless the amount billed each time exceeds $200.00, in which case you will receive notification in advance.

Name of Patient/Client_____

Account type *Visa *MasterCard *HSA *Discover

Account Number _____ Expiration Date _____
CVV (3-digit number on back of Visa, MasterCard, or Discover) _____

I authorize Hamzavi Psychiatry & Wellness Center to charge this credit card for professional services and associated charges as agreed below. These charges may include:

Pay for sessions taking place in the office: ☐
Insurance Deductible/Copay/Coinsurance: ☐
Charge for cancellation without 24 hours' notice or missed appointment: ☐
Pay for sessions taking place virtually (phone or Skype): ☐

I understand that this authorization will remain in effect until I cancel it in writing and I agree to notify this practice in writing of any changes in my account information or termination of this authorization.

Signature of Authorized Card User: _____ Date: _____

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CONSENT FOR ASSESSMENT AND TREATMENT ARBITRATION AGREEMENT AND PRIVACY POLICY

Please read this form carefully. It provides important information about your consent to treatment, a statement of your rights as a recipient of mental health services and a statement of privacy regarding your protected health information.

CONSENT TO TREATMENT

Patient Name (please print): _____

If not self, state relationship to patient: _____

I am voluntarily choosing to have psychological and/or psychiatric treatment and hereby acknowledge that I am over eighteen (18) years of age, of sound mind and competent to consent to treatment. I understand that as a patient/client of Hamzavi Psychiatry and Wellness Center, PLLC, I may receive a range of mental health and wellness services, the type and extent of which will be determined following an initial assessment.

Though my provider will do her/his best to fully advise me of the risks, benefits and alternatives to treatment options, I understand that the result of such treatment cannot be warranted or guaranteed. I understand that I will be responsible for participating in the development of my own treatment plan. I understand that it is my right and responsibility to voice any questions, concerns, objections or doubts I may have regarding the course of treatment to the professionals with whom I am in treatment. I intend that this consent form is to cover my entire treatment course for my present condition as well as any future conditions I may seek treatment.

ARBITRATION AGREEMENT

Arbitration means you waive your right to a jury trial. Due to the high costs of medical malpractice insurance and litigation, this office requires every patient sign an arbitration agreement. This means that all potential disputes are resolved through arbitration and not in court. This is mandatory for anyone who chooses to be a patient in our practice.

This is an agreement between the patient signed below (or the patient's designated guardian) and the clinicians of our practices: In the event of a dispute of any nature arising between the parties or their heirs at any time as a result of clinicians providing medical services, advice, treatment, informed consent, prescriptions, tests and procedures whether in person or by phone, text, writing, internet, in the home, office, hospital, or otherwise: The parties hereto agree to submit the dispute to binding arbitration under the rules of the Independent American Arbitration Association. An award rendered by the arbitrator(s) shall be final and binding upon the parties and judgement on such award may be entered by either party in the highest court having jurisdiction. Each party hereto specifically waives his/her right to bring the dispute before a court of law and stipulates that this agreement shall be a complete defense to any action instituted in any local, state or federal court or before any administrative tribunal.

I hereby am giving my consent knowingly and voluntarily without any element of force, deceit, duress or other form of constraint or coercion, with general knowledge of the medical and psychiatric procedures outlined above, am aware of the circumstances and am physically and mentally competent to give consent.

Patient Signature: _____ Date: _____

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NEW PATIENT MEDICATION REVIEW

_____ CHECK HERE IF YOU COMPLETED MEDICATIONS IN THE PATIENT PORTAL

Patient name:_____ DOB:_____

Date of Visit: _____

Names of **ALL** Current Medications	Dose (mg)	Frequency (ie. Bedtime only)	Refills Needed?	90 Day Supply?

- Do you forget to take your medication? How often? (# days/week): _____
- Are you having any **side effects**? If yes, how long have you noticed them?

  _____

  _____
- Please rate your **mood** today (1, worst to 10, best) _____**anxiety**? (10 being worst)_____
- How many hours do you **sleep** at night? _____Do you feel rested when you wake? _____
- Have you had any alcohol/marijuana/other drugs in the last 30 days? _____
- **Pharmacy Information:**

  Name/Address:_____

  Phone: _____

Weight: _____ ***Blood Pressure:*** _____ ***Heart Rate:***_____

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PAST MEDICAL AND SURGICAL HISTORY

_____ CHECK HERE IF YOU COMPLETED MEDICAL AND SURGICAL HISTORY IN THE PATIENT PORTAL

Patient Name:_____ **DOB**:_____

MEDICAL HISTORY

MEDICAL CONDITION	DIAGNOSED/DURATION

SURGICAL HISTORY

PROCEDURE	DATE OF PROCEDURE

Do you have a history of any of the following? If yes, check all that apply. If no, check here, ☐.

☐ Cardiac Problems (*arrhythmia, a-fib, coronary artery disease)*
☐ High Blood Pressure
☐ Glaucoma
☐ Tics
☐ History of Seizures: If yes, when?_____
☐ History of Head Injuries: If yes, when? _____
☐ Family History of Sudden Cardiac death

☐ Any known **ALLERGIES** to medications? If yes, name of medication(s) and reaction(s):

_____

_____

_____

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____ **DOB:** _____

I hereby grant my provider at Hamzavi Psychiatry & Wellness Center (Dr. Asra Hamzavi, Dr. Aimee Dereczyk, Deborah Warsh,LMSW, LMFT, ACSW, Emily Silver, LMSW) to release and/or receive information from the following person(s):

Suggested Persons	Name	Address	Phone/Fax
Primary Care Physician			
Therapist			
Spouse/Significant Other			
Parent			
Other			

Information to be disclosed may include: _____

I understand that the release of information to/from the person(s) listed above is for the purpose of enhancing the efficacy of my treatment.

Patient Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

□ I understand I may review a copy of Hamzavi Psychiatry & Wellness Center's Privacy Practices at www.hamzavipsychiatry.com

□ I understand I can request a copy of Hamzavi Psychiatry & Wellness Center's Privacy Practices.

Print Patient Name: _____

Signature: _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

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INSURANCE BENEFIT VERIFICATION FORM/AGREEMENT

(if applicable)

*****This page is for your information. It does not need to be returned.***

Hamzavi Psychiatry & Wellness Center (HPWC) only participates with Blue Cross Blue Shield PPO, Aetna PPO, and Priority Health Insurance. Patients using one of these plans are responsible for inquiring about their own mental health benefits. Please use the Insurance Verification form below to assist in determining your mental health benefits.

Helpful Information:

Deductible*: Deductible is the amount you pay for covered health care services before your* ***insurance*** *plan starts to pay. How it works: You will pay 100% of eligible health care expenses until the bills total your contracted deductible amount. After you pay your* ***deductible****, you usually pay only a copayment or coinsurance for covered services. Your* ***insurance*** *company pays the rest.*

Coinsurance*: Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the amount allowed to be charged for services. You start paying coinsurance after you've paid your plan's deductible. **Please note, once we receive payment from your insurance, the copay/coinsurance amount may need to be adjusted.*

Copayment*: A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. How it works: Your plan determines what your copay is for different types of services, and when you have one. You may have a copay before you've finished paying toward your deductible. You may also have a copay after you pay your deductible, and when you owe coinsurance. **Please note, once we receive payment from your insurance, the copay/coinsurance amount may need to be adjusted.*

Insurance Benefit Verification Information

Call the toll free number on the back of your insurance card. Ask for your "Outpatient Mental Health Benefits" or "Behavioral Health Benefits".

Date & time of your call: _____ *Person's name with whom you spoke:* _____

*Deductible: In-Network: _____ Out-of-Network: _____

*Co-pay: In-Network: _____ Out-of-Network: _____

*Maximum number of sessions/dollar amount per year: _____ Per lifetime: _____