Non-covered services, forms, letters, mailings, or non-approved (by insurance) appointments are billed directly to the patient/guarantor. We do not bill Medicaid. Change of Insurance or enrollment in Medicaid requires immediate notification to this office and you must pay directly for any non-covered costs.

Payment is due at time of service. Known co-pays and deductibles are due at time of service. Payment can be posted in your PORTAL at evansvillepsychiatric.com. Unpaid services that must be invoiced are subject to billing fees /late charges. Fees unpaid after 90 days may be turned to a third party collections agency. An additional fee of 33% will be added to the account and patients are responsible for this fee, and additional court costs and attorney fees. Checks returned for NSF will be charged up to $30.

If you are prescribed Schedule II medications, our office provides 3 ways to obtain monthly refills: Preferred by your PORTAL at evanvillepsychiatric.com. Daily (maintenance) medications should be requested through your pharmacy. If your INSURANCE requires a PA (Prior Authorization), your pharmacy will contact us and we will do our best to complete their requirements within 72 hours. PA's are solely due to your insurance; when your prescriber wrote the prescription that was THEIR authorization. If you are prescribed any Schedule II or IV drugs, you could be asked to complete an impromptu pill count or drug screen test. Keep your prescription(s) and medication(s) in a secure location. Some prescriptions are not replaceable.

Cancellation policy: Rescheduling must be made 24 hours in advance. Late cancellations or non-attended ("no-show") appointments will be billed a clinic and provider fee. Patients who have 2 No-Show or Late Cancellations within a 6 month period may be terminated from services without further warning. You must be on time for your appointment.

We are not a walk-in clinic. We do not have emergency staffing; always call ahead so we can provide better service. Preferred method of communication is through the website portal. When you leave a phone message, always leave a complete message with proper spelling of the patient name, the date of birth and what it is that you need. We will return your call as quickly as possible, but it may be the next day. When a follow-up appointment is requested, schedule your next appointment. We have an after-hours answering service for emergencies.

I authorize my insurance company to make payment directly to Evansville Psychiatric Associates for all appointments and charges made at Evansville Psychiatric Associates, unless I pay in full at the time of service. I understand that medical records may need to be released to my insurance company in order to substantiate claims. If needed, my signature may remain on file for use to file Medicare claims that I am responsible for. This office abides by HIPAA privacy laws. A copy of HIPAA regulations can be obtained on line or at our front desk.

Office closings will be posted to our Facebook page www.facebook.com/evansvillepsychiatric and phoned in to the local TV stations. Good mental health care requires mutual trust. We expect patients to be honest and we expect appropriate behavior in our clinic. We also ask you to report any problems to our office manager.

Evansville Psychiatric Associates Consent to Treat

Definition of Telehealth:
Telehealth involves the use of electronic communications to enable Evansville Psychiatric Associates mental health professionals to connect with individuals using interactive video and audio communications.
Telehealth includes the practice of psychiatry/psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:
1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CFS utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-tof-ace” psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. 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 counselor 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 that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

____ ________________________

Signature of Patient Date

____ ________________________

Signature of Parent/Guardian acknowledging the above. Date

(Please provide us with Court or other documentation as necessary. Indiana family law holds both parents ultimately responsible for medical bills.)